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PATIENTS' PERCEPTION OF DOCTOR-PATIENT HEALTH COMMUNICATION IN A RURAL COMMUNITY

ABSTRACT

Effective communication between healthcare provider and patient is crucial, yet research indicates that this communication relationship is often unsatisfactory in both developed and developing countries. Several studies exist on provider-patient communication, but a synthesis of findings on ideal communication appears to be lacking. Thus, this study argues that health literacy and effective communication are important catalysts to enhance the coordinated management of meaning in health communication. For this study, in-depth interviews were conducted in the Mafikeng community in South Africa's North-West province to collate a variety of patients' perspectives on the challenges they face when communicating with doctors. Recurrent among the findings were semantic, psychological, physiological, institutional and structural barriers that could hinder effective communication. Practical implications are that all stakeholders should be proactive in promoting effective health communication. Theoretical implications have a bearing on policy formulation, implementation and revision, particularly the indigenous language policy to promote research on the development of medical terminology in indigenous languages.

Keywords: communication barriers; doctor-patient interaction; health communication; health literacy; linguistic democracy; medicine labels; effective communication

INTRODUCTION

The study reported on in this article is based on the premise that inadequate doctor-patient health communication could result in the misinterpretation of information and the resultant misuse of medication and consequently poor health and unnecessary loss of life (Govender & Pen-Kekana 2008). Several factors influence the success or failure of medical health communication by both health practitioners and patients. Notably, high education levels might not necessarily imply health literacy (Berkman *et al.* 2010).

Several studies have been conducted on provider-patient communication (see Andaleeb 2001; Williams *et al.* 2013; Kennedy *et al.* 2014). However, a resulting synthesis of ideal

communication appears to be lacking. As such, a study by Heritage and Maynard (2006), which traced the main perspectives and lines of development that have emerged in 30 years of recorded doctor-patient interaction in the United States, concluded that it was difficult to generalise repeatedly observable medical interactions. Reasons provided were the complexities of disciplinary, methodological and ideological divisions that these authors (*ibid.*) viewed as relatively enduring features of the medical field. Based on the findings of that longitudinal study, it is logical to pursue effective healthcare provider-patient communication and to promote health literacy. A community approach could yield plausible solutions as patients mostly deal with the same healthcare providers and are likely to encounter similar communication challenges.

In this study, the researchers sampled patients from different educational backgrounds. Considering doctors' tight schedules, often abstract health jargon on doctors' prescriptions, the volatility of oral communication in the explanation of instructions, and the fact that medicine labels in pharmacies in South Africa are written in English and Afrikaans only, there is a challenge of enhancing effective communication with patients. In addition, oral explanations by doctors and pharmacists can be inadequate or patients might forget the information. Consequently, patients are vulnerable to the incorrect interpretation of prescription instructions and medicine use that could have adverse effects on their health.

It has to be acknowledged that some studies on health communication yielded positive health outcomes. Where oral communication is concerned, a study by Schillinger *et al.* (2003: 88), on the extent to which physicians assess patients' recall and understanding of information conveyed during an outpatient encounter, found the following: "Recall and comprehension was associated with improved glycemic control among patients with diabetes mellitus and low functional health literacy". However, Schillinger *et al.* (*ibid.*) pointed out that outcomes vary across racial, ethnic and socio-demographic lines, elaborating that "the prevalence of functional health literacy, especially among elderly persons, ethnic minorities and the socio-economically disadvantaged, coupled with the disproportionate burden that type-2 diabetes mellitus places on individuals, suggests that problems with health communication may contribute to disparities".

Of interest to the current study is that evidence of positive findings in some studies include or refer to measures taken to improve communication. For example, an American study by Kennedy *et al.* (2014) focused on a peer-facilitated communication skills building course for service providers and patients at a clinic in Arizona. The findings indicated that service improved after the course and provider participants experienced an 18% decrease in patients' complaints. A study by Williams *et al.* (2013: 15), on patient reported barriers to provider-patient communication, indicated that a large number of patients could not participate in healthcare due to several factors. These factors included "structural, such as poor continuity of care; predisposing, such as differences in personal traits between patient and clinician; interactional, such as power imbalance between patient and clinician; and preparatory factors, such as providing information about options". Williams *et al.* (*ibid.*) also noted that the more common view among clinicians was that patients did not want to participate. Therefore, exploring challenges faced by patients in communicating with doctors is key to unlocking health communication.

AIM OF THE STUDY

The main research question centred on patients' perception of the nature of doctor-patient health communication in the Mafikeng community in South Africa's North-West province, with a sub-question that focused on suggestions from participants, based on their perceptions of this communication relationship, of how doctor-patient health communication could be improved. The following aim was identified: To garner in-depth, rich, grassroots evidence about patients' perception of the nature of doctor-patient health communication in the Mafikeng community in order to identify and describe challenges faced by patients when they communicate with doctors. It is important to note that this study only investigated the perception of the nature of doctor-patient health communication in the Mafikeng community from the perspective of patients. Additional research is required to investigate the matter from the perspective of medical doctors in order to provide a more complete picture.

EVOLUTION OF THEORY ON HEALTH COMMUNICATION

Health communication has been defined as referring to "any type of human communication whose content is concerned with health, where the focus is on health-related transactions and the factors that influence these" (Rogers 1996, in Berry 2007: 2). Across developed and developing countries, the service provider-patient interface has frequently been described by patients as "discriminatory, marginalising, and abusive" (Govender & Pen-Kekana 2008: 90). This finding serves as a motivation for health literacy education that could enhance effective healthcare provider-patient communication. However, such effectiveness can only be sought after determining the challenges patients face in doctor-patient health communication. Although situated in the broad field of health communication, this study focused specifically on doctor-patient communication dynamics, and specifically from the perspective of patients in a largely rural community.

Problems of communication between doctors and patients are largely entrenched in transactional exchanges between the two parties. Therefore, theories drawn from interpersonal communication were found pertinent to guiding the study. Wood (2016: 14) defines interpersonal communication as "a selective, systemic process that allows people to reflect and build personal knowledge of one another and create shared meanings". Interpersonal communication is systemic, so, "situation, time, people, culture and personal histories interact to affect meanings" (Wood 2016: 15). If the above-mentioned factors are not diligently considered in doctor-patient communication, there is likely to be adverse effects on patients' health. Several theories of interpersonal communication have been propounded but the coordinated management of meaning theory (CMM) (Littlejohn & Foss 2009), which advocates participatory communication, has been found particularly relevant in guiding doctor-patient communication.

COORDINATED MANAGEMENT OF MEANING THEORY

The CMM theory is based on the assumption that meaning creation is achieved by applying rules based on the content of communication; the actions being performed;

the situation; the relationship between the communicators; individual backgrounds; and cultural patterns. In this case, healthcare ethics should embrace a two-way communication process, which involves the patient in decision-making (Berry 2007). Pearce and Cronen (1970, in Littlejohn & Foss 2009) argue that the goal of communication is for communicators to reach a level of coordination.

CMM began as an interpretive theory primarily focusing on interpersonal communication, then developed a critical edge in work in a wide range of communication settings, and has now transformed into a practical theory that collaborates with practitioners to improve the patterns of communication (Pearce & Pearce 2000). Coordination is about conjointly creating meaning by the participants, while management of meaning is the process by which people tell stories in order to interpret the world around them and place themselves in it (Pearce 1999). Thus, CMM could be crucial in doctor-patient communication as it is likely to produce desirable health communication outcomes.

However, one major problem of CMM, according to Barger (2004), is that it becomes difficult to determine under which conditions people's lives improve, given that incidents of CMM not producing desired results in therapeutic and consulting cases often go unreported. Barger (*ibid.*) reiterates the significance of ethics in health communication, including that patients should know their rights regarding health communication and receive satisfactory service from practitioners. This knowledge is enhanced by health literacy which, as mentioned earlier, is lacking in both developed and developing countries (Leavitt & Leavitt 2011).

CCM AND CULTURE

According to an Institute of Medicine report published in 2003, the concept of culture has increasingly become a core component in the development of health communication theory and application (Littlejohn & Foss 2009). The goal of culturally sensitive health communication theories is to utilise the concept of culture to develop more effective and efficient health communication programmes amongst the members of various cultures (*ibid.*). In order to address the concept of culture in health communication, scholars and practitioners have introduced culturally based constructs into existing health communication theories. One such construct is the participatory approach, which could yield healthy communities as it recognises all communicating participants' voices. Participation is based on the premise that the active engagement of relevant stakeholders in the communication process renders patients empowered (Tuftte & Mefalopoulos 2009). Participation becomes a pertinent proposition in health communication, but it has to be enhanced through health literacy. Chambers (1994; 2002, in Cleary *et al.* 2015), an influential early practitioner and scholar of participatory approaches, argues that the capacities of facilitators, in this case healthcare providers, and the style of facilitation are crucial. This implies adequacy and expertise from doctors, as well as good rapport with patients.

CMM and its tenet of participation largely draw from the transactional model, which states that "the transactional nature of interpersonal communication implies that communicators share responsibility for effectiveness" (Wood 2016: 22). Transactional

models illustrate simultaneous interaction of complex, multi-layered elements of the communication process, which influence one another (Barker & Gaut 2002). A “transaction” occurs when two people are in conversation and the emphasis is on verbal and non-verbal behaviour as it occurs in the context of the encounter (Hill *et al.* 2007). However, to describe a transaction as complementary does not imply that the responses are always appropriate (*ibid.*). Therefore, doctors should collaborate with patients in decision-making so that patients understand the reasons for certain actions; thus empowering patients to be in charge of their health decisions.

COMMUNICATION BARRIERS

Wood (2016: 22) refers to the inevitability of noise (communication barriers) in a communication encounter. Physiological noise refers to factors affecting the proper functioning of the body, such as hunger, pain or fatigue. Psychological noise refers to the qualities in us that affect how we communicate and how we interpret others. For example, failure by patients to express themselves and to open up to a doctor, say due to lack of courage or cultural differences, may lead to wrong diagnosis, just as failure by a doctor to give full attention to a patient and clarify information may result in misinterpretation (Wood 2016). Semantic noise exists when words (language) are not mutually understood, for example due to the use of medical jargon, which could result in patients misinterpreting information.

LINGUISTIC DEMOCRACY IN HEALTH COMMUNICATION

Littlejohn and Foss (2009; cf. Hussey 2013) state that cultural competence by health practitioners is important as it facilitates greater respect from patients. The institutional and structural silencing of patients’ and communities’ non-English voices prevents community involvement in their health welfare (Hussey 2013). Therefore, a democratic language policy could be viewed as crucial in giving patients a voice. According to Levin’s 2006 study, language and cultural barriers were cited by more parents of patients as a major barrier to healthcare than structural and socioeconomic barriers (Hussey 2013). Studies have shown that miscommunication caused by the language barrier results in increased patient avoidance behaviour, which may result in later presentation of disease, adding to the uncertainty and emotional stress experienced by patients (Deumert 2010; Saha & Fernandez 2007).

In order to enhance meaning, organisation and design are key aspects of plain language communication, considering that patients may understand and retain only half of what they are told during a clinical encounter (McCarthy *et al.* 2012). However, retention and comprehension could improve significantly if patients are asked to restate, in their own words, the information communicated to them (Bertakis 1977, in Martin & Lipman 2013). Arguably, patients can only perform this function if they are competent in the language used. Symbols are arbitrary, meaning that words are not intrinsically connected to what they represent. The arbitrary nature of language is evident, for example, when communicators discover that their words do not have the same meaning in another culture (Martin & Lipman 2013). Therefore, it is crucial

for both parties in a communication transaction to put in as much effort as possible in order to understand each other.

While other countries may have a national language to facilitate communication, South Africa has 11 official languages. Although various measures to improve communication, such as interpreting services, are available (Department of Arts and Culture 2013), current findings indicate ineffective implementation. A study on the viability of interpretation conducted at Madwaleni in the Eastern Cape indicated that communication was often in the hands of untrained or inexperienced interpreters, as well as professional medical staff, junior or student nurses, patients' family members and auxiliary staff (Hussey 2013). Typically at Madwaleni, a communication barrier often exists between doctor and interpreter and between interpreter and patient (*ibid.*). Another method of overcoming the language barrier is code-switching, "a linguistic phenomenon where speakers change between two languages in a single sentence or conversation" (Hussey 2013: 191); this is only possible if both parties understand both the languages used.

It has been noted that, apart from a few exceptions (in Tanzania, Somalia, Ethiopia and Eritrea), most African countries have promoted and entrenched a neo-colonial policy in which English, French or Portuguese continue to be dominant. Thus, the gap of social class, race, gender and particularly language often separates service providers from clients (Mpasha & Lesebe 2015). These authors state that "health education materials should include local languages. These health education materials such as videos, story boards, TV, radio, songs and community theatre should be incorporated effectively to introduce health messages where there is a lack of literacy" (Mpasha & Lesebe 2015: 93).

HEALTH LITERACY AND POLICY

The US Healthy People Report (2010, in Kickbusch 2001: 293) defines health literacy as "the capacity to obtain, interpret and understand basic health information and services and the competence to use such information and services to enhance health". A broader definition by Nutbeam (1998, in Kickbusch 2001: 293) says "health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health". Nutbeam (2006, in Berkman *et al.* 2010: 12) elaborates that "in addition to literacy and numeracy, rhetorical discourse (effective speaking, listening, and writing), the ability to use technology (particularly the Internet), motivation, cognitive ability, and networking and social skills" also constitute health literacy. The main theme emanating from the definitions above is the ability to use different communication resources to enhance health communication.

Across definitions, outcomes are related to the health of the individual, but vary in nuance. One could argue that a population's health literacy would be higher if health-related materials and communication incorporate more universally integrated principles of clear language, making these materials easier to understand (Berkman *et al.* 2010). Therefore, policymakers should consider developing clear standards for both the format

and content of prescription drug labels, for example. Such strategies may improve the “likelihood that patients will understand, safely administer, and adhere to their drug therapy” (Shrank *et al.* 2009: 798). Yet, even seemingly insignificant factors, such as a physician’s illegible handwriting, could contribute to medical errors (Bhosale *et al.* 2013; Sadananda 2016). In fact, Sadananda (2016: 40) writes that “30 000 British die every year due to medical errors” that result from “unclear abbreviations, dosage indications, and illegible writing out of the 3.2 billion prescriptions written in the UK every year”.

The goal of health literacy is to enable the patient to make informed judgments about when, for example, it is advisable to seek expert advice from a health professional, knowledge of how to find the appropriate professional, and the ability to explain the health problem and personal concerns that made the consultation necessary (Schulz & Nakamoto 2013). A study by Stevenson *et al.* (2004) on analysis of consultations found scant evidence for the occurrence of shared decision-making, with one party often blaming the other for lack of effort. The lack of synthesis in the various studies on doctor-patient communication justifies the current study.

RESEARCH METHODOLOGY

The study was conducted as a qualitative cross-sectional survey of patients’ perceptions of doctor-patient health communication. The population of the study comprised black people living in the Mafikeng community who have been patients and have consulted with private doctors in Mafikeng. The study focused on private doctors because the majority of these work alone, without the help of nurses, as is often the case in the public sector. The sample comprised 30 interviewees, both male and female, from the ages of 18 and above, across educational backgrounds, and within the 11 linguistic backgrounds of South Africa. A snowball sampling strategy was used based on whether the respondent had consulted with a private doctor and obtained a prescription and medicine. This method was deemed appropriate as people generally prefer to keep health matters confidential, and snowball sampling is often used when members of a population are difficult to locate (Tichapondwa 2013). Permission for the study was obtained from the research entity, Indigenous Language Media in Africa, while an ethical clearance certificate was also applied for through the appropriate institutional structures. Research participants were briefed and informed consent was sought from the interviewees.

Data gathered was based on the following concepts: reception and interaction; instruction; prescription interpretation; and understanding medicine labelling. Question types used were adopted from Du Plooy (2009) and Geilfus (2008) and included dichotomous, follow-up, mirror and open-ended questions in order to elicit underlying information and suggestions. Data was transcribed from the interviews by means of emic analysis in which the interviewees’ categorisation of behaviour was regarded as the reality in the study context. The researchers moved from emic to etic analysis where the interviewees’ views were evaluated through conceptual categories from the literature and theory to provide a grounded and detailed description of patients’ perceptions of challenges faced in terms of doctor-patient communication (Lindlof &

Taylor 2011). Categories were then compared and their interrelationship formed the basis for the theoretical and practical implications for health communication.

DISCUSSION OF FINDINGS

The findings were based on four conceptual categories deemed crucial in health communication: doctor-patient reception and interaction; prescriptions; instructions; and medicine labels. The majority of the respondents were Setswana (22; n=30), the dominant language in the North-West province. The rest of the sample was made up as follows: Zulu (2), Xhosa (4), Ndebele (1) and Sesotho (1). The following sections provide a discussion of findings that relate to the study's main objective, namely to describe patients' perception of the nature of doctor-patient health communication in the Mafikeng community.

Doctors' confirmation of patient's proficiency in the language used

When asked which language the doctors they have consulted with use, the majority of the research participants indicated English. Some participants indicated that the doctor used their (the doctor's) local language, while others indicated that the doctor used both English and a local language(s). All the participants indicated that the doctor they consulted did not confirm whether the patient understood the language they (the doctor) were using before proceeding, nor did they ask the patients which language they spoke. One participant said, "If a doctor speaks to me in a language I don't understand, I quickly switch to English since it is the official language in South Africa". However, the same participant added, "the problem with some foreign doctors, even if they use English, you may fail to understand them because of their accent".

One major challenge emerging from this result is the inadequacy of patients' linguistic democracy in their interaction with doctors due to linguistic differences. Interpretation services were not viewed as the best option as it carried the risk of misinterpretation, which is in line with previous findings (Hussey 2013; Deumert 2010). Instead, participants' suggestions to overcome the semantic barrier include access to doctors who have been living in the community for a long time, as well as the production of health education media and materials in local languages, supported by findings from Hussey (2013) and Mpasha and Lesebe (2015). The authors of this article argue that all stakeholders, including patients, should be proactive in ensuring attainment of the best health outcomes.

Patients' preferred language/s in doctor-patient communication

The majority of the participants indicated that they prefer to use their home language when communicating with doctors, yet they indicated that this is difficult since the majority of private doctors do not speak a local language, or in some cases are not South African. However, 11 out of 30 participants cited English as their language of preference when communicating with doctors, indicating that English is the medium of instruction in South Africa. Two of these participants acknowledged the importance

of using mother-tongue languages for the less literate and elderly people. One respondent explained their preference of English as follows:

“It is easier to express myself in English because my home language may be difficult to express some medical concepts and terms ... Doctors take advantage of patients who can't express themselves in English and make decisions for them, for example, one doctor suggested several tests for my mother without clarifying what exactly he was investigating and without agreeing with her.”

A major concern expressed that emerged from the interviews was that doctors should get the correct information on patients' problems to avoid misinterpretation. One participant preferred using both English and IsiXhosa, indicating that due to certain cultural taboos, particularly where a doctor and patient differ in gender, some concepts are difficult to express in IsiXhosa. One can then switch to English, which relates to “code-switching”, as mentioned earlier.

Doctor-patient reception and interpersonal interaction

The major challenge identified in terms of the participants' perception of doctor-patient interaction, both for explanations given by both parties and for instructions from doctors, was the language barrier. Related was the challenge of the accent of foreign doctors and, in some instances, white South Africa doctors. As a result, some participants indicated that they sometimes end up withholding information because they are not confident to express themselves in a second language. One concern raised was that even if doctors have nurses or other healthcare staff who can assist in interpreting, these nurses/staff are not trained interpreters, which can result in misinterpretation.

Another concern that emerged was the failure to understand medical terminology, especially in instances where the participants felt that the doctor did not explain thoroughly enough. Participants' suggestions for improvement of doctor-patient health communication in this regard include the use of trained interpreters based on the province's dominant language; doctors learning the language of the community to embrace local culture through staying in the community for a long time; and that doctors use simple language to explain medical terms, which is also advocated by CMM (Littlejohn & Foss 2009).

Several other challenges of human nature, particularly psychological, were mentioned by participants, for example, indications that some doctors ask patients questions but do not elaborate on patients' responses. The perception that certain race groups receive preferential treatment was also raised, and one participant mentioned that “whites do not get into queues at some white doctors”. Some participants experienced doctors as unfriendly, lacking patience and compassion, unreceptive, inconsiderate, or intimidating. Physiological barriers were also reported. Some participants experienced doctors as impatient, reportedly as a result of tight schedules or fatigue. Statements supporting the above include:

“In some doctors, there are long queues. The doctor does not have enough time to attend to each person adequately.”

Patients' perception of doctor-patient health communication

"Some doctors if you ask questions they feel threatened and see you as a forward somebody; you can see the facial expressions and you end up being quiet."

"Some doctors are unconcerned. They continue to write a prescription even if you tell them you are not improving because they want you to continue coming to their surgery; they don't want to carry further tests or refer you."

"When I went for a review, the doctor said I have a different problem without carrying further tests and felt neglected."

"Patients fear the unknown. Doctors don't counsel patients, they don't have euphemism, so patients develop a phobia to ask doctors. If you are told you have one month to live, it crushes you."

Some participants indicated that they had to seek clarity to understand doctors' instructions. Those participants who indicated that they sometimes understand oral instructions better also mentioned the dilemma of then forgetting this information.

Patients' challenges in understanding prescription content and medicine labels

The majority of the participants was concerned about some doctors' illegible handwriting and the use of medical jargon, which support findings by Sadananda (2016). The major concern is the need to take medicines correctly, according to the doctor's instructions. The following concerns were noted (here participants included references to both doctors and pharmacists):

"So that I know whether I can get the medicine over the counter because it is more expensive with a prescription."

"So that I know the side effects and make an informed decision."

"At one time I was given a wrong dose for the child's medicine at the pharmacy and the child would spend the whole day sleeping. I googled and discovered that the dose written was much higher for children."

"At one time the pharmacist gave us alternative cream for my sister's daughter and she reacted the whole body, so we had to go back to the doctor, and it was very expensive for us to consult and to buy other medications again ... since then, I do not like substitutes."

One participant indicated that sometimes both doctors and pharmacists do not explain which medicine is for what ailment or symptom in instances where one is given more than one type of medication:

"Sometimes doctors prescribe many pills for one problem and you do not know which one is more important than the others."

Concerning medicine labelling, the majority of respondents indicated that they had problems understanding the labels. Most of them said they had to seek clarity from pharmacists. One issue raised was inadequate information on the label, and that oral

explanations on use could easily be forgotten (Shrank *et al.* 2009; cf. Schillinger *et al.* 2003). Participants' suggestions in this regard include that medicine labels should have universal pictures in order to be more informative and to enhance understanding. For example, one participant said:

"The label just says 2 times per day and I don't know which 2 times of the day, some don't indicate whether it should be before or after food. The instruction sheet inside has so much information I do not know where to start and it has medical jargon which I don't understand."

Improvement of doctor-patient health communication

As a secondary objective, the participants were asked for suggestions on the improvement of doctor-patient health communication, based on their perception of challenges that they experience in this regard.

The language barrier was prominent among challenges that emerged from analysing patients' perception of doctor-patient health communication. The majority suggested the recruitment of trained interpreters to help patients express themselves in instances where the doctor's and patient's language differs, although it was reiterated that it is not the best solution due to the risk of misinterpretation. One suggestion was that doctors should ask patients their language of preference, where possible. Another suggestion was that a doctor should learn the language of the community in which they are serving for basic communication; this is possible if doctors stay longer in the particular community. Further, it was indicated that doctors should use simple English to explain health conditions and the names of medicines to enhance understanding.

Concerning reception, several suggestions were presented by participants. Primary among these is that it is essential that there should be a good rapport between the doctor and patient to ensure quality service. Other participants suggested that doctors attend workshops that are contextual, for example, language or culture specific.

Concerning health media, some respondents preferred the use of typed and printed prescriptions to those that are hand-written. One participant suggested that doctors should devise questionnaires so that patients who are not comfortable expressing their problem could write it down. Another participant indicated that doctors' surgeries should be information hubs that provide patients with free or affordable information on different health issues. The same participant pointed out that entertainment magazines seem to be more readily available than healthcare information in some doctors' surgeries.

Where the patients' initiative is concerned, some participants suggested that patients need a lot of exposure to deal with sensitive and cultural concepts. As such, health literacy and awareness campaigns were found to be useful engagements nationwide so that patients could open up on their health issues. Another indication was that patients should know their health rights in order to lodge complaints when something goes wrong in the process of seeking medical attention. One participant suggested that patients should use non-verbal communication in instances where they struggle

to express themselves in a second language. Generally, the respondents' suggestions were an appeal for commitment from both sides to improve communication.

Policy improvement

The majority of the participants voiced the desire for the implementation of a language policy in the health sector. Suggestions included that basic language interpretation be incorporated in health training. The government was urged to enforce policy that allows patients to use the dominant language of a particular province and that a doctor who is not competent in that language should employ an interpreter.

With regard to health literacy, one crucial concern is that health literacy should be implemented through various programmes to reach a wider audience, and that the quality of these programmes be monitored and evaluated regularly. To enhance an inclusive policy, it was suggested that the government forms a partnership with the private health sector to standardise healthcare practice to accommodate patients from different socio-economic backgrounds. This emanated from the concern that patients do not follow up on their health progress with private doctors because these medical professionals' services are more expensive. It was also suggested that effective tools for quality assurance be implemented, particularly in the private sector. One participant suggested the use of patients' suggestion boxes in all private surgeries, "monitored by government employees", as well as patient surveys as some of the tools for monitoring and evaluation.

Concerning health media policy improvement, it was suggested that medicine labels should have universal symbols for easier identification and should entail informative pictures to help patients understand how to use medicines. It was also suggested that medicine labels be written in a third language, the dominant language of a particular province, and be distributed as such; and that research should be conducted to find appropriate words or terms that describe medical terminology in these languages. The concern was that currently medicine labels in South Africa are written in only English and Afrikaans, to the exclusion of all other official languages.

To summarise the patients' perceptions of doctor-patient health communication in a largely rural area, the major themes emerging from the findings were: a lack of linguistic democracy resulting in semantic breakdown; ineffective doctor-patient reception and interpersonal interaction in general and health communication in particular; ineffective instructions; illegible prescriptions or prescriptions that are difficult to understand, resulting in wrong dosage instructions; and inadequate medicine labelling.

CONCLUSION

The study's findings concluded that, based on the perception of participating patients, doctor-patient health communication is inadequate in the Mafikeng community due to several semantic, physiological, psychological, institutional and structural barriers. The authors are of the opinion that effective implementation of the CMM theory could improve doctor-patient health communication. The practical implications of the study are largely entrenched in the promotion of health literacy. Incorporation of

interpreters or the use of interpretation services in health training programmes were also suggested. Theoretical implications include the improvement and implementation of a health communication policy, particularly a language policy; research on the translation of medical terminology to all official languages; and inclusion of all official languages in health communication media and medicine labels.

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