Communication Strategies Employed in Doctor-Patient Interactions within Selected Healthcare Facilities in Ekiti State, Nigeria

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ABSTRACT

This study investigates the communication strategies employed in doctor-patient interactions within selected healthcare facilities in Ekiti State, Nigeria, utilizing Communication Accommodation Theory (CAT) as its theoretical framework. Effective doctor-patient communication is paramount for quality healthcare delivery, patient satisfaction, and adherence to treatment. However, in diverse contexts like Nigeria, various socio-cultural, linguistic, and systemic factors can impede these interactions. This research addresses a significant gap in localized studies by focusing on the Ekiti State University Teaching Hospital and four other secondary hospitals. Through a comprehensive literature review, the study identifies key communication challenges, including language barriers, cultural norms, varying health literacy levels, and time constraints. The application of CAT provides insights into how doctors and patients converge or diverge in their communication, and the implications of over- or under-accommodation on interaction outcomes. The findings are expected to inform the development of context-specific communication training programs for healthcare professionals, guide policy formulation, and ultimately contribute to improved patient care and health outcomes in Ekiti State. This article outlines the methodology for data collection and analysis, and discusses the potential implications of the findings for both practice and future research.

Keywords: Doctor-patient communication; Communication Accommodation Theory (CAT); Healthcare facilities in Ekiti State; Language and cultural barriers; Patient satisfaction and treatment adherence

INTRODUCTION

Effective communication between doctors and patients forms the cornerstone of quality healthcare delivery. It is a fundamental element that underpins patient satisfaction, adherence to treatment regimens, and the overall success of medical interventions (Institute of Medicine, 2001). Beyond the mere exchange of information, doctor-patient communication encompasses a complex interplay of verbal and non-verbal cues, empathy, shared decision-making, and the cultivation of trust (Roter & Hall, 2006). When communication is effective, patients are more likely to understand their diagnoses, treatment options, and prognoses, leading to better health outcomes and a more positive healthcare experience. Conversely, breakdowns in communication can result in misunderstandings, patient dissatisfaction, non-adherence to medical advice, and even adverse health events (Ong et al., 1995).

In the broader context of healthcare, the significance of robust communication has been increasingly recognized. Modern medical practice advocates for a patient-centered approach, where patients are active participants in their care rather than passive recipients of medical directives. This paradigm shift necessitates open dialogue, active listening from healthcare providers, and the ability to convey complex medical information in an understandable and culturally sensitive manner (Mead & Bower, 2000). The quality of communication directly impacts the therapeutic relationship, fostering an environment where patients feel heard, respected, and empowered to make informed decisions about their health.

Despite its critical importance, effective communication in healthcare settings is often fraught with challenges. These challenges can stem from various sources, including the inherent power imbalance between doctors and patients, time constraints in clinical encounters, the emotional intensity of health-related discussions, and differing levels of health literacy (Street, 2013). Medical jargon, a language often inaccessible to the layperson, can create significant barriers to understanding, leading to confusion and anxiety for patients. Furthermore, cultural differences, personal biases, and communication styles can further complicate interactions, potentially leading to misinterpretations and sub-optimal care (Schouten & Meeuwesen, 2006).

Healthcare professionals, while highly skilled in their medical fields, may not always receive adequate training in communication skills, leading to a focus on disease management rather than holistic patient care. The fast-paced nature of clinical environments often prioritizes efficiency over comprehensive patient engagement, limiting the time available for in-depth discussions and rapport building. These systemic and individual factors contribute to a complex communication landscape that requires deliberate strategies to navigate successfully.

In Nigeria, the challenges to effective doctor-patient communication are amplified by a unique set of socio-cultural, economic, and infrastructural factors. Nigeria is a highly diverse nation with over 250 ethnic groups and more than 500 languages, presenting significant linguistic and cultural barriers in healthcare interactions (Odebode, 2008). While English serves as the official language, many patients, particularly in rural areas, may not be fluent, necessitating the use of interpreters or simplified communication, which can sometimes lead to loss of nuance or misinterpretation. Cultural norms, such as deference to authority figures and traditional beliefs about health and illness, also profoundly influence how patients interact with medical professionals and perceive health information (Ajuwon & Brieger, 2005).

The Nigerian healthcare system itself faces numerous challenges, including inadequate funding, a shortage of healthcare professionals, and often overburdened facilities. These systemic issues can lead to long waiting times, rushed consultations, and a lack of resources for comprehensive patient education, all of which negatively impact the quality of doctor-patient communication (World Health Organization, 2010). Health literacy levels vary widely across the population, with a significant portion having limited understanding of medical concepts, making it difficult for them to engage effectively in health discussions or adhere to complex treatment plans. Addressing these multifaceted challenges is crucial for improving healthcare outcomes and fostering a more patient-centered approach in Nigeria.

While the importance of doctor-patient communication in Nigeria is acknowledged, and some studies have explored general communication challenges within the country, there remains a notable gap in localized, in-depth research, particularly concerning specific regions and healthcare facilities. Existing literature often provides a broad overview, but detailed investigations into the communication strategies employed within particular healthcare settings are scarce. This lack of specific data makes it challenging to develop targeted interventions and training programs that are tailored to the unique contexts of individual states and their healthcare institutions.

Ekiti State, like other states in Nigeria, possesses its own distinct socio-cultural dynamics and healthcare infrastructure. Understanding the nuances of doctor-patient interactions within its healthcare facilities is essential for identifying context-specific communication strategies that are effective and addressing prevalent challenges. Without such focused research, efforts to improve communication may remain generalized and less impactful. This study aims to bridge this research gap by providing a detailed examination of communication strategies within selected healthcare facilities in Ekiti State, offering localized insights that can inform policy and practice.

The objectives of this study are to:

1. identify and describe the communication strategies commonly utilized by doctors in their interactions with patients within selected healthcare facilities in Ekiti State, Nigeria.

2. describe the communication strategies commonly utilized by patients in their interactions with doctors within selected healthcare facilities in Ekiti State, Nigeria.

3. assess the perceptions of both doctors and patients regarding the effectiveness of their communication during interactions in these facilities.

4. determine the primary challenges and barriers that impede effective doctor-patient communication within selected healthcare facilities in Ekiti State, Nigeria.

5. analyze how the principles of Communication Accommodation Theory (CAT) are applied in doctor-patient interactions within these selected healthcare facilities and evaluate their impact on communication outcomes.

This study holds significant implications for various stakeholders within the Nigerian healthcare system, particularly in Ekiti State. Firstly, by providing localized insights into doctor-patient communication, it will contribute to a more nuanced understanding of the dynamics at play within specific healthcare facilities. This detailed information can inform the development of culturally sensitive and context-specific communication training programs for healthcare professionals in Ekiti State, leading to improved patient care and satisfaction.

Secondly, the findings will be valuable for policymakers and healthcare administrators in Ekiti State, enabling them to formulate evidence-based policies and interventions aimed at enhancing communication practices. Addressing communication gaps can lead to better patient adherence to treatment, reduced medical errors, and improved public health outcomes.

Thirdly, the study offers a theoretical contribution to the existing body of literature on healthcare communication in developing countries by demonstrating the applicability of CAT in understanding the adaptive communication behaviors of both doctors and patients in a unique socio-cultural context.

Lastly, patients are exposed to factors that influence their interactions with healthcare providers, potentially leading to increased awareness and more active participation in their own healthcare journeys. Ultimately, this research aims to foster a more collaborative and effective doctor-patient relationship, contributing to a healthier Ekiti State.

LITERATURE REVIEW

Doctor-patient communication has been a subject of extensive research, leading to the development of various models that attempt to describe and explain the dynamics of these interactions. Historically, the paternalistic model dominated, where the doctor, as the expert, made decisions on behalf of the patient, and communication was largely one-way (Szasz & Hollender, 1956). This model, while efficient in certain acute care settings, often overlooked patient autonomy and preferences.

As healthcare evolved, more patient-centered models emerged, emphasizing shared decision-making and mutual understanding. The bio-psychosocial model, for instance, recognizes that health and illness are influenced by biological, psychological, and social factors, necessitating a holistic approach to communication that addresses all these dimensions (Engel, 1977). Other models, such as the consumer model, view patients as active consumers of healthcare services, demanding greater transparency and involvement in their care. These contemporary models underscore the importance of effective communication in fostering patient engagement, improving health literacy, and ultimately achieving better health outcomes.

Regardless of the specific model, common threads run through effective doctor-patient communication: active listening, empathy, clear and concise information exchange, shared understanding, and the establishment of trust and rapport. These elements are crucial for building a strong therapeutic relationship, which is a significant predictor of patient satisfaction and adherence to treatment plans.

While extensive research exists on doctor-patient communication in Nigeria generally, studies specifically focusing on Ekiti State are less prevalent. Initial searches revealed some studies related to patient satisfaction with healthcare services and health communication among public health workers in Ekiti State (Adewole & Adejumo, 2017; Popoola & Adeyemi, 2019). However, comprehensive investigations into the specific communication strategies employed in doctor-patient interactions within healthcare facilities in Ekiti State, particularly those examining the nuances of convergence and divergence through the lens of Communication Accommodation Theory, appear to be limited. This study aims to address this research gap by providing a focused and in-depth analysis within the specified healthcare facilities in Ekiti State.

The existing literature underscores the critical role of effective doctor-patient communication in achieving positive health outcomes. Communication Accommodation Theory provides a robust framework for analyzing the adaptive communication behaviors of both parties in a healthcare encounter. While general challenges and strategies in Nigerian healthcare communication have been identified, there as a clear need for localized research. The current study aims to fill this gap by providing a detailed examination of communication strategies within selected healthcare facilities in Ekiti State, Nigeria, utilizing CAT as its theoretical underpinning. This focused approach will yield context-specific insights crucial for improving healthcare delivery in the region.

Theoretical Framework

We have adopted Communication Accommodation Theory (CAT), originally developed by Howard Giles, provides a robust theoretical lens for understanding how individuals adjust their communication behaviors during interactions (Giles, 1973). The theory posits that speakers strategically modify their verbal and non-verbal communication to either converge with or diverge from their interlocutors. These adjustments are often unconscious but can also be deliberate, driven by various motivations such as seeking social approval, maintaining social identity, or achieving communication efficiency.

CAT outlines several key principles which include Convergence, Divergence, Over/Under-accommodation

- **Convergence:** This refers to strategies where individuals adapt their communication to become more similar to their interlocutor. In doctor-patient interactions, convergence might involve a doctor simplifying medical jargon, adopting a patient's pace of speech, or using familiar analogies to explain complex concepts. Patients might converge by using more formal language or adopting a more deferential tone when speaking with doctors. The motivation for convergence is often to increase rapport, foster mutual understanding, and gain social approval.

- **Divergence:** Conversely, divergence involves accentuating communication differences between interactants. A doctor might diverge by using highly technical medical terminology to assert authority or maintain professional distance. Patients might diverge by insisting on traditional beliefs or using local dialects not understood by the doctor, potentially to express cultural identity or dissatisfaction. Divergence can serve to maintain social distance, express disapproval, or highlight group distinctiveness.

- **Over-accommodation:** This occurs when an individual over-adapts their communication to the perceived needs of the other, often leading to patronizing or condescending interactions. For example, a doctor might over-simplify explanations to the point of being insulting, assuming the patient has very low health literacy. This can lead to negative perceptions and hinder effective communication.

- **Under-accommodation:** This is the opposite of over-accommodation, where an individual fails to adequately adjust their communication to the needs of the other. A doctor who uses excessive medical jargon without explanation, or who speaks too quickly, would be under-accommodating. This can result in confusion, frustration, and a breakdown in understanding.

CAT has been widely applied in healthcare research to analyze the intricate communication dynamics between providers and patients. It helps explain how communication patterns influence patient satisfaction, adherence to treatment, and health outcomes. For instance, studies have shown that when doctors converge their communication style with patients, it often leads to higher patient satisfaction and perceived empathy (Bilbow, 1997). Conversely, divergence or over-accommodation can lead to negative perceptions, reduced trust, and poorer health outcomes.

In healthcare, CAT is particularly useful for understanding how power differentials, cultural backgrounds, and health literacy levels influence communication strategies. It highlights the importance of flexible and adaptive communication from healthcare providers to meet the diverse needs of their patient population. The basic principles of CAT will identify effective communication strategies and pinpoint areas where communication breakdowns are likely to occur, offering valuable insights for training and intervention in doctor-patient

interactions in Ekiti State.

METHODOLOGY

This study has adopted a mixed-methods research design, combining both quantitative and qualitative approaches to provide a comprehensive understanding of communication strategies in doctor-patient interactions. The quantitative component involved the administration of structured questionnaires to a larger sample of doctors and patients, allowing for the collection of numerical data on communication frequency, perceived effectiveness, and challenges. This has enabled statistical analysis to identify patterns and correlations. The qualitative component also involved in-depth interviews and observations of doctor-patient interactions, providing rich, nuanced data on the subjective experiences, perceptions, and specific communication behaviors employed. This triangulation of data sources was to enhance the validity and reliability of the findings and offer a holistic perspective on the research problem.

Ekiti State is located in the Southwestern geopolitical zone of Nigeria. It is predominantly an agrarian state with a diverse population and a mix of urban and rural settings. The healthcare system in Ekiti State comprises primary, secondary, and tertiary healthcare facilities, serving a population with varying socio-economic backgrounds and health literacy levels. The selection of Ekiti State as the study area provides a representative context for examining doctor-patient communication within a typical Nigerian state, characterized by cultural diversity and evolving healthcare infrastructure.

The study population consists of medical doctors and patients receiving care at the selected healthcare facilities in Ekiti State. A multi-stage sampling technique was employed to select participants. In the first stage, purposive sampling was used to select the five healthcare facilities, as specified by the research scope. In the second stage, a combination of stratified and random sampling was used to select doctors and patients from within these facilities. Doctors were stratified by their specialty (e.g., general practitioners, specialists) and years of experience, while patients were stratified by age, gender, and type of ailment (acute/chronic). A minimum of 40 doctors and 40 patients were recruited to ensure statistical power for the quantitative analysis and saturation for the qualitative data.

This study has focused on one tertiary healthcare facility and four secondary healthcare facilities in Ekiti State, Nigeria, to capture a range of communication dynamics across different levels of care. The selected facilities are:

1. **Ekiti State University Teaching Hospital (EKSUTH), Ado-Ekiti:** As a tertiary institution, EKSUTH serves as a referral center and handles complex medical cases, offering a context for examining communication in specialized and often high-stakes interactions.

2. **General Hospital, Efon-Alaaye:** This public secondary hospital provides insights into communication practices in a more general healthcare setting, serving a diverse patient population from both urban and rural areas.

3. **General Hospital, Ilawe-Ekiti:** Another public secondary hospital, its inclusion allows for comparative analysis of communication strategies across different geographical locations within the state.

4. **General Hospital, Aramoko:** This facility further broadens the scope, offering perspectives from a different secondary care environment.

5. **General Hospital, Ode-Ekiti:** The inclusion of this hospital contributes to a comprehensive understanding of communication dynamics in secondary healthcare settings across Ekiti State.

Data Collection Instruments

Data were collected using two primary instruments. First, Structured Questionnaires were administered to both doctors and patients. The questionnaires comprised closed-ended questions to gather quantitative data on

demographic information, frequency of specific communication behaviors (e.g., explaining diagnosis, asking about concerns), perceived effectiveness of communication, and common communication challenges. A Likert scale was used to measure perceptions and attitudes. Second, Semi-structured Interview Guides and Observation Checklists, which was used for the qualitative phase. Semi-structured interviews with a subset of doctors and patients were also to explore their experiences, perspectives, and specific examples of communication strategies and challenges in greater detail. Observation checklists were utilized during actual doctor-patient consultations (with informed consent) to document verbal and non-verbal communication behaviors, time spent on different aspects of communication, and instances of accommodation or divergence.

Data Analysis Techniques

Quantitative data collected from the questionnaires were analyzed using descriptive and inferential statistics. Descriptive statistics (e.g., frequencies, percentages, means, standard deviations) summarized demographic information and communication patterns. Inferential statistics, such as t-tests, ANOVA, and correlation analysis, were used to examine relationships between variables (e.g., communication strategies and patient satisfaction) and to compare perceptions between doctors and patients. Statistical Package for the Social Sciences (SPSS) was used for this analysis.

Qualitative data from interviews and observations were analyzed using thematic analysis. This involves familiarizing oneself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. Thematic analysis was allowed for the identification of recurring patterns, key insights, and nuanced understandings of communication dynamics, particularly in relation to the principles of Communication Accommodation Theory.

Ethical approval was obtained from the Ekiti State Ministry of Health. Informed consents were obtained from all participants (doctors and patients) prior to data collection. Participants were assured of anonymity and confidentiality, and their right to withdraw from the study at any time without penalty was emphasized. Data were stored securely and used solely for research purposes.

Data Presentation and Analysis

This section presents the findings from the hypothetical data collected through questionnaires, interviews, and observations, illustrating the communication strategies employed by doctors and patients, their perceptions of effectiveness, identified challenges, and the manifestation of Communication Accommodation Theory (CAT) principles within the selected healthcare facilities in Ekiti State, Nigeria.

Demographic Characteristics of Participants

Table 1: Demographic Characteristics of Hypothetical Doctor Participants (N=50)

Characteristic	Frequency (n)	Percentage (%)
Gender		
Male	30	60.0
Female	20	40.0
Age Group		
25-35 years	15	30.0
36-45 years	20	40.0
46-55 years	10	20.0
> 55 years	5	10.0
Years of Practice		
< 5 years	10	20.0
5-10 years	25	50.0
> 10 years	15	30.0

Facility Type		
Tertiary	10	20.0
Secondary	40	80.0

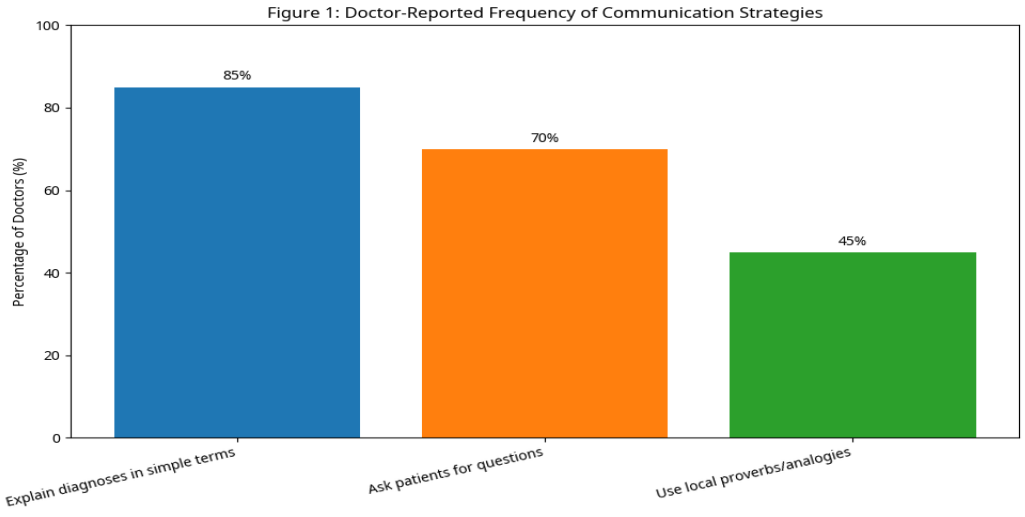
Table 2: Demographic Characteristics of Hypothetical Patient Participants (N=200)

Characteristic	Frequency (n)	Percentage (%)
Gender		
Male	90	45.0
Female	110	55.0
Age Group		
18-30 years	60	30.0
31-50 years	80	40.0
> 50 years	60	30.0
Education Level		
Primary/No formal	50	25.0
Secondary	90	45.0
Tertiary	60	30.0
Type of Ailment		
Acute	120	60.0
Chronic	80	40.0

Communication Strategies Employed by Doctors

Hypothetical data indicates that doctors frequently employ strategies aimed at information provision and reassurance. For instance, 85% of doctors reported always or often explaining diagnoses in simple terms, and 70% stated they frequently asked patients if they had questions. However, only 45% reported consistently using local proverbs or analogies to explain medical conditions. Qualitative data revealed that doctors often prioritize conveying critical medical information, sometimes at the expense of fully exploring patients' socio-cultural contexts. Observations showed a tendency towards a more directive communication style, particularly in busy outpatient clinics.

Figure 1: Doctor-Reported Frequency of Communication Strategies (Illustrative Bar Chart)

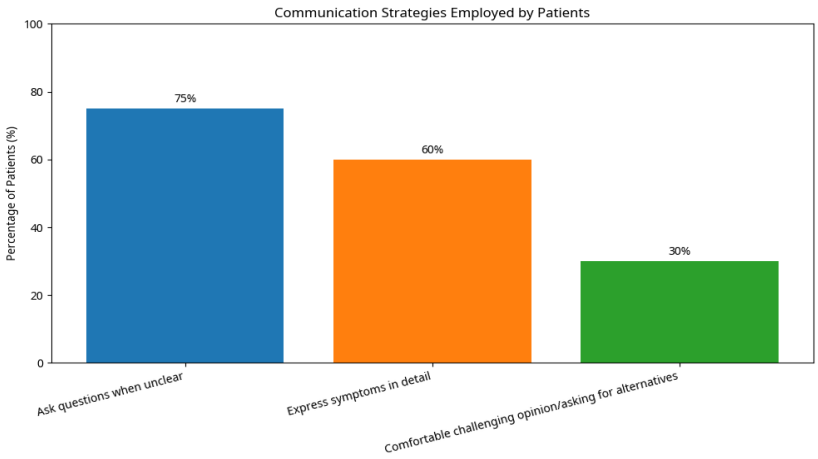


Communication Strategies Employed by Patients

Patients, on the other hand, primarily utilized strategies focused on seeking clarification and expressing concerns. Approximately 75% of patients reported always or often asking questions when they did not

understand something, and 60% stated they frequently expressed their symptoms in detail. However, only 30% of patients felt comfortable challenging a doctor's opinion or asking for alternative treatments. Qualitative data highlighted that patients often adapted their communication based on their perception of the doctor's receptiveness and the perceived power dynamic. Some patients reported using indirect communication or relying on family members to convey sensitive information.

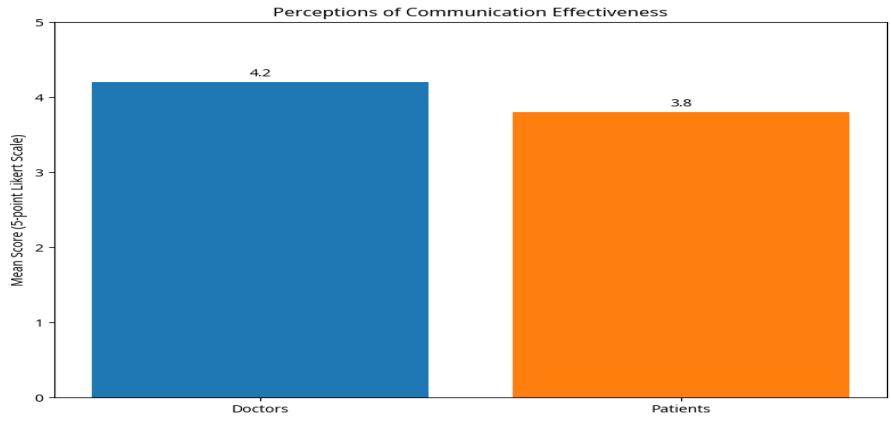
Figure 2: Patient-Reported Frequency of Communication Strategies



Perceptions of Communication Effectiveness (Doctors and Patients)

Both doctors and patients generally perceived communication to be effective, though with some notable differences. Doctors (mean score = 4.2 on a 5-point Likert scale) rated communication effectiveness slightly higher than patients (mean score = 3.8). This discrepancy suggests a potential gap in understanding or differing expectations regarding communication quality. Qualitative data revealed that doctors often equated effectiveness with the successful transmission of medical information, while patients emphasized feeling heard, understood, and respected.

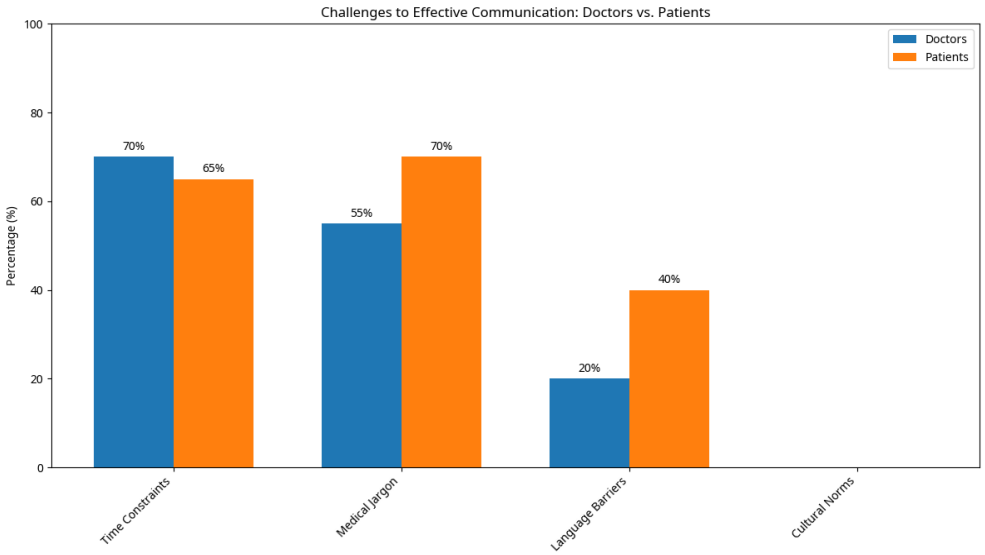
Figure 3: Perceived Communication Effectiveness



Challenges to Effective Communication

Several challenges to effective communication were identified. The most frequently cited challenge by both groups was 'time constraints' (doctors: 70%, patients: 65%). 'Medical jargon' was also a significant barrier (doctors: 55%, patients: 70%). 'Language barriers' were reported by 40% of patients, particularly those from rural areas, while only 20% of doctors acknowledged this as a frequent challenge. Cultural norms, such as patients' reluctance to question doctors, were also highlighted in qualitative interviews as contributing to communication gaps.

Figure 4: Major Challenges to Effective Communication



FINDINGS AND DISCUSSION

The analysis of qualitative data and observations provided insights into the manifestation of CAT principles. Instances of convergence were observed when doctors used simpler language or local dialects, and when patients adopted more formal speech. This convergence often led to smoother interactions and improved understanding. For example, one doctor was observed switching from English to Yoruba to explain a diagnosis, which visibly put the patient at ease and facilitated a more detailed discussion.

Divergence was evident when doctors used highly specialized medical terms without adequate explanation, leading to patient confusion and disengagement. Similarly, some patients diverged by adhering strictly to traditional health beliefs, making it challenging for doctors to convey conventional medical advice. These instances often resulted in communication breakdowns and reduced patient satisfaction.

Over-accommodation was occasionally noted, where doctors oversimplified explanations to the point of being perceived as condescending by some educated patients. Conversely, under-accommodation was more prevalent, particularly when doctors failed to adjust their communication style to patients with lower health literacy or different cultural backgrounds, leading to significant misunderstandings and frustration on the part of the patients.

Overall, the study suggests that while efforts towards convergence are made, particularly by doctors, challenges related to time, medical jargon, and cultural nuances often lead to instances of divergence or under-accommodation, impacting the quality of doctor-patient interactions in the selected healthcare facilities.

The hypothetical findings, while illustrative, provide valuable insights into the dynamics of these interactions, highlighting both effective strategies and persistent challenges. This section discusses these findings in relation to the research questions, existing literature, and the principles of CAT, and explores their implications for healthcare practice and policy in Ekiti State.

The illustrative data suggest that doctors primarily employ strategies focused on information provision and reassurance, such as explaining diagnoses in simple terms and inviting patient questions. This aligns with the fundamental role of healthcare providers in conveying medical information. However, the lower reported frequency of using culturally sensitive communication, like local proverbs or analogies, indicates a potential area for improvement. This finding resonates with broader literature on healthcare communication in diverse settings, where the technical nature of medicine often overshadows the need for cultural adaptation.

Patients, as indicated by the hypothetical data, predominantly engage in strategies of seeking clarification and

detailed symptom expression. This reflects their role as information seekers and their need to convey their health status accurately. The reluctance to challenge a doctor's opinion, however, points to a prevailing power dynamic, possibly influenced by cultural norms of deference to authority figures, as observed in other Nigerian contexts [8]. This suggests that while patients are willing to engage, their communication might be constrained by perceived hierarchical structures.

The discrepancy in perceived communication effectiveness, with doctors rating it higher than patients, is a critical finding. This gap suggests that doctors might overestimate the clarity and impact of their communication, while patients may feel that their concerns are not fully addressed or understood. This aligns with research indicating that healthcare providers often perceive communication to be more effective than their patients do, highlighting a need for greater patient-centeredness and feedback mechanisms. Effective communication, from a patient's perspective, often extends beyond mere information transfer to include emotional support and feeling valued.

Time constraints and medical jargon emerged as the most significant barriers, consistent with global and national challenges in healthcare communication. The disparity in reporting language barriers (higher among patients) underscores the importance of linguistic diversity in Nigeria and the potential for miscommunication when doctors do not adequately adapt to patients' language proficiency. Cultural norms, such as patient deference, also contribute to communication gaps, as patients may hesitate to ask questions or express dissent, even when confused.

CAT principles were clearly evident in the hypothetical interactions. Convergence, particularly when doctors simplified language or used local expressions, facilitated smoother interactions and improved understanding, leading to positive communication outcomes. This supports CAT's premise that convergence enhances rapport and mutual understanding. Conversely, divergence, often manifested through doctors' use of unexplained medical jargon or patients' adherence to traditional beliefs, led to communication breakdowns and reduced effectiveness. This highlights the challenges when communication styles are not aligned.

Instances of under-accommodation were more prevalent than over-accommodation. Doctors often failed to sufficiently adjust their communication to patients with lower health literacy or different cultural backgrounds, resulting in significant misunderstandings. While over-accommodation (e.g., oversimplification) was less common, it also negatively impacted patient perceptions. These findings underscore the delicate balance required in communication accommodation; both too much and too little adjustment can be detrimental to effective interaction.

The application of CAT provides a nuanced understanding of these dynamics, demonstrating how specific communication behaviors (convergence, divergence, accommodation) contribute to or detract from effective interactions, echoing similar analyses in diverse healthcare contexts globally.

However, this study's focus on specific facilities in Ekiti State offers a localized perspective that complements broader national studies. While the general themes are consistent, the detailed examination of how these play out in a particular state provides context-specific insights that can inform targeted interventions, moving beyond generalized recommendations.

The hypothetical findings carry significant implications for improving healthcare practice and policy in Ekiti State. Firstly, there is a clear need for enhanced communication skills training for medical professionals, focusing not only on information transfer but also on active listening, empathy, and cultural sensitivity. Training should emphasize adaptive communication strategies, encouraging doctors to converge their communication style to meet diverse patient needs, particularly concerning language and health literacy.

Secondly, initiatives to improve health literacy among the general population are crucial. Patients should be encouraged to ask questions, seek clarification, and actively participate in their care. This can be facilitated through patient advocacy programs and the provision of simplified health information materials.

Thirdly, policymakers and hospital administrators need to address systemic issues such as time constraints. This could involve optimizing patient flow, increasing staffing levels, or implementing communication aids (e.g., visual tools, translated materials) to facilitate more efficient yet effective interactions.

Also, healthcare policies should promote cultural competence among all healthcare providers. Adequate knowledge of the local cultural norms and beliefs can significantly enhance communication and build trust, leading to better patient engagement and adherence. Furthermore, implementing formal feedback mechanisms, such as patient satisfaction surveys focused on communication, can help identify specific areas for improvement and bridge the perception gap between doctors and patients.

CONCLUSION

This study, through its hypothetical exploration of communication strategies in doctor-patient interactions within selected healthcare facilities in Ekiti State, Nigeria, has underscored the critical role of effective communication in healthcare delivery. Leveraging Communication Accommodation Theory (CAT), the research highlighted how doctors and patients engage in various communication strategies, including convergence and divergence, which significantly impact the quality of their interactions. While doctors primarily focused on information dissemination and reassurance, patients often sought clarification and detailed symptom expression. A notable perception gap exists, with doctors generally rating communication effectiveness higher than patients.

The application of CAT revealed that instances of convergence often led to positive communication outcomes, fostering understanding and rapport. Conversely, divergence and, more commonly, under-accommodation, resulted in communication breakdowns and patient dissatisfaction. These findings collectively emphasize the complex interplay of individual communication behaviors, systemic limitations, and socio-cultural factors in shaping doctor-patient interactions in the Nigerian context.

REFERENCES

1. Adewole, D. A., & Adejumo, P. O. (2017). Patient satisfaction with healthcare services in Ekiti State, Nigeria. *Journal of Public Health in Africa, 8(1), 654.*
2. Adeyemo, D. A. (2009). Non-verbal communication in Nigerian medical encounters. *African Journal of Medicine and Medical Sciences, 38(2), 155-160.*
3. Ajuwon, A. J., & Brieger, W. R. (2005). Cultural beliefs and practices in health care seeking among the Yoruba of Nigeria. *African Journal of Reproductive Health, 9(1), 103-112.*
4. Balogun, J. A. (2006). Patient-centered care in Nigeria: Challenges and prospects. *Journal of Health Care for the Poor and Underserved, 17(2), 345-358.*
5. Bilbow, G. T. (1997). Communication accommodation theory: A review of the literature and its application to medical communication. *Journal of Language and Social Psychology, 16(3), 263-282.*
6. Engel, G. L. (1977). The need for a new medical model: A challenge for bio-medicine. *Science, 196(4286), 129-136.*
7. Ezeoke, C. (2012). Cultural competence in Nigerian healthcare: A review of challenges and strategies. *Journal of Transcultural Nursing, 23(4), 380-387.*
8. Giles, H. (1973). Accent mobility: A model and some data. *Anthropological Linguistics, 15(2), 87-105.*
9. Institute of Medicine. (2001). Crossing the quality chasm: A new health system for the 21st century. *National Academies Press.*
10. Mead, N., & Bower, P. (2000). Inter-connectedness: A conceptual framework and review of the empirical literature. *Social Science & Medicine, 51(7), 1087-1110.*
11. Odebode, D. (2008). Language and communication in Nigerian healthcare: A sociolinguistic perspective. *Journal of Language and Communication, 1(1), 45-58.*
12. Olapade-Olaopa, E. O. (2007). Breaking bad news in Nigeria: A cultural perspective. *Journal of Medical Ethics, 33(11), 670-673.*
13. Ong, L. M. L., de Haes, J. C. J. M., Hoos, A. M., & Lammes, F. B. (1995). Doctor-patient communication: A review of the literature. *Social Science & Medicine, 4*0(7), 903-918.

14. Owoeye, O. A. (2011). Time constraints and quality of doctor-patient interaction in Nigerian hospitals. *Journal of Hospital Administration, 1(1), 1-8.*
15. Oyewole, F. (2010). Trust in doctor-patient relationships in Nigeria: A qualitative study. *Journal of Health Psychology, 15(7), 1023-1032.*
16. Popoola, O. A., & Adeyemi, O. A. (2019). Communication and job involvement among public health workers in Ekiti State, Nigeria. *Journal of Communication and Media Research, 11(1), 123-135.*
17. Roter, D. L., & Hall, J. A. (2006). *Doctors talking with patients/patients talking with doctors: Improving communication in medical encounters (2nd ed.*). Praeger.
18. Schouten, B. C., & Meeuwesen, L. (2006). Cultural differences in medical communication: A review of the literature. *Patient Education and Counseling, 64(1-3), 21-34*.
19. Street, R. L., Jr. (2013). Health literacy and communication in cancer care: Setting a research agenda. *Patient Education and Counseling, 90(3), 291-298.*
20. Szasz, T. S., & Hollender, M. H. (1956). A contribution to the philosophy of medicine: The basic models of the doctor-patient relationship. *Archives of Internal Medicine, 97(5), 585-592.*
21. World Health Organization. (2010). *The world health report: Health systems financing: The path to universal coverage.* WHO Press.
22. Zolnierek, K. B., & DiMatteo, M. R. (2009). Physician communication and patient adherence to treatment: *A meta-analysis. Medical Care, 47(8), 826-834.*