SOCIO-ECONOMIC AND CULTURAL FACTORS AFFECTING PHYSICIAN-PATIENT INTERACTION: THE CASE OF HARAMAYA GENERAL HOSPITAL, MAYA CITY, OROMIA NATIONAL REGIONAL STATE

MA THESIS

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SCHOOL OF GRADUATE STUDIES

I hereby certify that I have read and evaluated this Thesis prepared under my guidance by Mohammedin Ahmed entitled **"Socio-economic and cultural factors affecting physician-patient interaction: The case of Haramaya general hospital, Maya City, Oromia National Regional State.** I recommend that it be submitted as fulfilling the thesis requirement.

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As a member of the board of examiners of the MA Thesis open Defense Examination, we certify that we have read and evaluated the thesis prepared by Mohammedin Ahmed and examined the candidate. We recommend that the Thesis to be accepted as fulfilling the thesis requirements for the degree of Master of Arts in Sociology.

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This thesis is dedicated to my parents for their incredible sacrifice in my life's success. I also dedicate this work to my friends and colleagues who have supported me until the thesis has completed.

STATEMENT OF THE OUTHOR

By my signature below, I declare and affirm that this Thesis is my own work. I have followed all ethical and technical principles of research in the preparation, data collection, data analysis and completion of this thesis.

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ABSTRACT

The purpose of this study was to assess the socioeconomic and cultural factors affecting the interaction between doctors and patients in Haramaya general hospital, Maya City, Oromia regional state. In order to achieve the study's goal, a descriptive cross-sectional research design was used, which combines a quantitative and qualitative research approaches. The quantitative data was collected from 384 respondents through questionnaires and qualitative data were collected from medical director and two physicians of the hospitals management team member through key informant and in-depth interview tools of data collection. The quantitative data was analyzed through descriptive statistics in the form of tables, frequency distribution and percent. The qualitative data from respondents through key informants and in-depth interviews was analyzed through careful interpretation of meaning based on the objectives of the study. Previous studies have focused largely on waiting time, cost of the treatment, patient satisfaction and not much has been documented on in-patient outcome of health care seeking in tertiary institution from the point of view of the patient themselves. This study, investigated the socio-economic and cultural factors that affect physician-patient interaction focused on in-patient case with care in Haramaya general hospital, Maya City, Oromia National Regional State. As the study indicated, as a result of socio-economic and cultural factors, the interaction between patients and physicians were poor and patients faced the problems of poor communication, they did not have a good relationship with their physicians in medical care. It is recommended that physicians and hospital management bodies should pay proper attention to how to interact with patients in order to eliminate the unfavorable conditions affecting the physician-patient interaction and consider the patients socioeconomic status and cultural issues related to health care during consultation with their patients.

Keywords: Socio-Economic factors; Cultural factors; Physicians; In-patients; Interaction

1. INTRODUCTION

1.1. Background of the Study

The relationship between the patient and the physician is described as "the relationship in which the patient intentionally seeks help from a physician and the physician accepts and consents to the individual as a patient" (Honavar, 2018). The "traditional" patient-physician relationship, from the times of Hippocrates, has changed over the years, and the roles and attitudes have been revised. Patients who were passive in exchanging information with physicians became more active today, initiating a process of change. Similarly, the inclusion of a patient in more holistic consultations in a focused manner further accelerated this change (Nikiphorou and Berenbaum, 2018). After this change, a patient-centered approach has emerged, which is seen as a central component of quality health care today. This approach appears to provide many advantages both for the patient and the physician. From the patients' perspective, satisfaction levels will increase, health information levels become better, personal care behaviors will change, admissions or hospital stays decrease. From the perspective of physicians, however, job satisfaction levels and self-confidence will increase, stress and burnout levels decrease (Casu et al., 2019).

Over the years, there have been changes to the interactions between doctors and patients from paternalistic model to patient centered approach. Before the last 20 years, most interactions were a patient asking for assistance and a doctor whose judgments complied with the patients silently followed. The doctor uses his expertise to select the essential interventions and therapies that are most likely to improve the patient's condition or lessen his suffering in this paternalistic model of the doctor-patient interaction. Patients may require more information during the consultation and more actively involved in the choice of the treatment. However, any information provided to the patient is chosen with the intention of persuading them to accept the doctor's judgment in the study. The idea of unbalanced or unequal relationship between doctors and patients has been challenged due to their socioeconomic status (Kaba and Kumaran, 2007).

As the studies done at the local health center in Bahirdar shows, the longer members of low socioeconomic categories were there, the more likely they were to be mistreated and treated with contempt. Patients who have low incomes and educational backgrounds are affected by the disdain and abuse that doctor’s exhibit toward them. These problems lead the patients to the problems of ignoring the patients’ question, the problem of listening, less attention to understand

the need of patients in health care, physicians' sense of self-superiority may resulted in poor service utilization in medical care (Jalil *et al*, 2017). Patients' incomes were the predictors of their social class. Patients with higher incomes, those who were more in educational attainment received more biomedical consultations than patients with medium and lower income level (Siminoff,. *et al* 2009).

Socioeconomic factors including gender of the physicians, educational attainment of the patients and their religious beliefs also play a major role in the medical relationship and influence how patients and their doctors interact. Current research examines whether or not a doctor's gender affects how well they communicate with patients. For example, it is said that doctors who are female have a more patient-focused style. Female doctors exhibit higher levels of consociation, empathy, boldness, and patient visits. Furthermore, due to a range of socioeconomic and cultural circumstances, interactions between patients and doctors had an impact on how decisions were made and how they interact with one another in the context of medical care like the importance of family and friends, religion, educational level, income, social values, and social norms (korfage, 2013; Jalil 2017 and Mitchell., *et al* 2012).

Physician-patient interaction is a situation which frequently happened any time between health care providers and patients who need help from them in medical care. Good physician-patient interaction is an important social services that enable patients to make good participation and well decision making process between patients and their physicians. Good physician-patient interaction is also important to enhance the patient's ability to understand what the physicians said while examination and medical diagnosis practiced. In line with this, a study conducted by Mahamud (2009) suggested that, the doctor-patient relationship is essential to the medical field and is required to provide high-quality medical care for illness diagnosis and treatment. For example, for patients to readily recall their medical history of diseases, clinicians and patients communicate well with health care providers. This can result in favorable outcomes for both parties and create relationships that are advantageous to the course of treatment. In addition, positive doctor-patient relationships aid in the identification of the patient's main health concerns (Berhane, 2016).

However, there is the problem with disrespect and abuse which is frequently occurred on patients whose educational level, occupation, and income are low and so there is the problem to

understand what the physicians said in physician-patient interaction because of the social, economic and cultural factors. In medical care, healthcare professionals frequently rush into therapy without properly interacting with their patients and fail to include them in decision-making (Wassihun, 2017).

Because of this, the researcher was greatly motivated to address the issues and carry out the study that concentrated on the socioeconomic and cultural factors affecting the physician-patient interaction in Haramaya general hospital, Maya City, Oromia Regional State.

1.2. Statement of the Problem

The relationship between a doctor and patient is fundamental in medical profession and is necessary for providing excellent healthcare for the diagnosis and treatment illnesses. Therefore, when patients come to the hospitals, they have a clear need or desire for care. However, there is no a sufficient reaction to their demands or expectations, Patients who have less attention for their health issue may become dissatisfied. While knowing the needs and expectations of the patients help to establish a good connection for the desired outcome, these desires and expectations could affect how patients interact with their physicians (Mahamud, 2009).

Physician-patient interaction is an important element of patient centered care that can improve patient safety and health care outcomes (Rathert et al,. 2017). It is important for health care providers to address specific health care needs and desired outcomes to improve patient-centered care. There is a need to involve patients when developing patient safety programs to provide patient-centered care and improve health care outcomes (Trier et al,. 2015). Physicians should understand the importance of patients opinions when designing a plan that affect them as far as the delivery of care is concerned. However, achieving patient centered care can be challenging when the communication between physicians and patients is not effective (Levinson et al,. 2010).

For instance, physicians may not understand what patients are communicating when they are distracted during medical encounters. These problems becomes challenging to provide effective care services that meet the needs of every patient. Hence, patients simply convinced to take the medicine and got treatment without any participation or patient centered approach in physician-patient interaction. Patients from lower social classes are often disadvantaged because of the doctor's misperception of their desire and need for information and the respondents' ability to take part in the care process (Wilson *et al*, 2003).

In addition to this, there is insufficient comprehension of patients with their physicians, low physicians view of health and wellness to respondents' health care and also the patient themselves perception of care is considered as the problems which leads poor physician-patient interaction and patients poor treatment in the interaction (Fowler, 2008 and Jalil 2017).

Furthermore, health care providers start treating patients using his or her expertise and without consideration to the patient's involvement or the course of treatment. For instance, when patient's case is referred to the medical emergency setting, their idea, question and the patients' preference is more undermined in physician-patient interaction. Patients from lower socioeconomic statuses perceived clinicians spent less time with them during consultations and were less attentive and less empathetic, which negatively affect their perception, about the information-sharing and shared decision-making processes (Hollender, 1956).

Some studies and assessment conducted so far have focused largely on waiting time, cost of the treatment, and patient satisfaction with regard to outpatient department case (Kassim, 2018, Eyoel, 2020). Nevertheless, to obtain respondents who received care in the emergency case and outpatient department throughout the study's data collection period is challenging and not much has been documented on in-patient outcome of health care seeking from the point of view of the patient themselves with regard to socioeconomic and cultural factors that affect physician-patient interaction in the area of the study.

Thus, this study attempted to address and explore the gaps as well as the problems mentioned above by examining socio-economic and cultural factors affecting physician-patient interaction that was not considered in some studies conducted so far.

1.3. Objectives of the Study

1.3.1. General objective

The general objective of this study was to assess socio-economic and cultural factors affecting physician-patient interaction: The Case of Haramaya general hospital, Maya City, Oromia National Regional State.

1.3.2. Specific objectives

The study aims to:

- Examine socio-economic factors affecting physician-patient interaction.
- Investigate cultural factors affecting physician-patient interaction.

1.4. Research Question

- What are the socio-economic factors affecting physician-patient interaction?
- What are the cultural factors affecting physician-patient interaction?

1.5. Significance of the Study

The results of this study can assist individuals involved in healthcare in identifying obstacles that doctors and patients encounter when interacting with one another. Additionally, it provides awareness for health stakeholders and acts as a Launchpad for additional study on physician-patient interaction. The research finding would be useful for researchers and other health stakeholders who are interested in exploring related research topics further.

1.6. Scope of the Study

This study was delimited only to one hospital setting due to time and financial constraints and the socio-economic and cultural factors affecting physician-patient interaction while other factors that may affect the interaction between the two parties were not considered. So this study was focused on the socio-economic and cultural factors believing that they are the major ones and largely referred by several studies. The study was delimited to 9500 sample frame by focusing on only inpatient department case in dealing with two approaches in a descriptive cross-sectional study design. Respondents those who were not willing to participate, who were critically ill, who cannot speak and listen, who have some forms of cognitive disorder were excluded during data collection.

1.7. Operational Definition of Key Terms

Physician: A person who interacts with patients and has received scientific training in the diagnosis, treatment and prevention of diseases.

In-patient: person who received/need treatment from a doctor or other medically educated person waiting in the hospital setting for a period of time.

Interaction: conversation or exchange of ideas between patients and physicians in medical care.

Socioeconomic factors: were the elements such as family role, religion, gender of physicians, marital status, educational level, occupational status and income that have to do with financial and social difficulties that affect the physician-patient interaction in medical care.

Cultural factors: were the elements such as social value, social norm, physicians and patients' perception of care, view of health and wellness that affect how doctors and patients perceived sickness and medical care which lead lack of communication and low level of physician-patient interaction in health care system.

2. REVIEW OF RELATED LITERATURE

2.1. An Overview of Physician-Patient Interaction

One of the most important aspects of practicing medicine is the relationship between the doctor and the patient, or more precisely the interaction between the two. The doctor-patient relationship was first theorized by social scientist Talcott Parsons. As per his perspective, the responsibility of a physician is to convey and depict knowledge about sickness to their patients in order to manage their deviation, while maintaining emotional distance between the doctors and patients (Person, 1951).

Doctor-Patient Relationship can be referred as a consensual relationship in which the patient knowingly seeks the physician's assistance and in which the physician knowingly accepts the person as a patient (Szasz and Hollender, 1956; Dwolatzky *et al.*, 2006). The physician-patient relationship is the foundation of clinical care. Physician-patient relationship can have profound positive and negative implications on clinical care. Ultimately, the overarching goal of the physician-patient relationship is to improve patient health outcomes and their medical care. Stronger physician-patient relationships are correlated with improved patient outcome. As the relationship between physicians and patients becomes more important, it is essential to understand the factors that influence this relationship. Patients sometimes reveal secret worries and fears to physicians that they have not yet disclosed to friends or family members. Placing trust in a doctor helps them maintain or regain their health and wellbeing (Helin, 2002; Curran 2007).

Although there are several factors that influence physician-patient relationship, the dynamic shared and sense of trust between physicians and patients are two critical components to their overall relationship. The dynamic between physicians and patients refers to the communication patterns and the extent to which decision making is shared between both parties. Effective physician-patient communication is an integral part of clinical practice and serves as the keystone of physician-patient relationships. However, this is not always the case in D-P interaction. Even if they share the same language, miscommunication and misunderstanding can occur due to different levels of literacy, knowledge and expertise. When miscommunication occurs, it can have severe negative implications in clinical care such as impeding patients understanding, treatment planning and decreasing patient satisfaction of medical care. In addition

to having effective communication, it is important that medical decisions stem from a collaborative process between physicians and patients. Decision making is a process in which patients should be involved from the very beginning and the result is a decision which reflects the physician's medical knowledge as well as the patient's values and beliefs (Lee, 2002).

Considerable attention has been paid to patients' beliefs about and desires for control in medical interactions; however, there are few studies on physicians' perceptions of their relationship with patients. Even more striking is the dearth of information on both physicians' and patients' perceptions of their relationship. A clear understanding of how perceptions about patient-physician relationships relate to patients' outcomes will assist health educators to develop more effective programs oriented toward enhancing care. This understanding may also help providers in establishing more satisfying relationships with patients. As documented in numerous studies, patient satisfaction is an important component of quality of care because it is linked to numerous other patient outcomes, such as adherence to the prescribed therapy, dropping out of care and malpractice litigation.

Interpersonal communication can be completely or partially influenced by physicians' personal biases, whether conscious or not. These biases may disadvantage groups of people who are vulnerable or socially disadvantaged due to their socioeconomic status, including employment or income status, ethnic or socio-cultural background, gender or sex, education status, and literacy or health literacy. These biases influencing interpersonal communication have been documented to impact different aspects of care. Patients from lower socioeconomic statuses perceived physicians spent less time with them during consultations and were less attentive and less empathetic, which negatively affected their perception of the information-sharing and shared decision-making processes. Doctors' communicative style is influenced by the way patients communicate. Patients from higher social classes communicate more actively and show more affective expressiveness, eliciting more information from their doctor. Patients from lower social classes are often disadvantaged because of the doctor's misperception of their desire and need for information and their ability to take part in the interaction process (Wilson *et al*, 2003).

Enhancing the care provided to patients, adherence to treatment, and health outcomes all depend on effective interpersonal interactions between healthcare professionals and patients. Patients are more satisfied with the care they receive and were more likely to stick to treatment plans if they

have faith in the physician and aware of the nature of their condition and how it is being treated (Meinam, 2015).

Patients from a lower social class and doctors often find themselves in a vicious circle. These patients' communication and actions (e.g. less question asking, less opinion giving, less affective expressiveness, less preference for decision making) elicit a less involving behavior from the doctor, with less partnership building utterances, which discourages the patient to adopt a more active communication style. There is evidence that socioeconomic status (SES) affects individuals' health outcomes and the health care they received. People of lower SES are more likely to have worse self-reported health, lower life expectancy, suffer from more chronic conditions when compared with those of higher socioeconomic status. They receive fewer diagnostic tests and medications for many chronic diseases and have limited access to health care due to cost and coverage. and also when compared with other patients, physicians are less likely to perceive low socioeconomic status patients as intelligent, independent, responsible or rational and believe that they are less likely to comply with medical advice and return for follow-up visits (Begley C,. et al,. 2011).

Like patients, physicians have also feelings, thoughts, and views they got from interviews. In this context, physicians may not be objective in the interviews and may be adversely affected in the relations with the patient. For example, an atheist physician will not be able to use God as a source of solace for the patient. Similarly, a physician who believes that human life is entirely sacred will less likely to recommend euthanasia or termination of pregnancy. Indeed, where the physician will stand in the patient's private life is a debated issue. It is generally stated that physicians must be sensitive to all the patient needs and act according to the behaviors of patients (who may not want to explain their personal opinions) in order to improve the quality of care (Bulduklu, 2015).

In terms of literacy, patients with lower educational levels may have difficulty reading their prescriptions, appointment slips, tests and procedure preparation instructions, which may have a negative effect on their interaction with the physician. In the same way, patients with better educational level and higher socioeconomic background are known to be more in contact with physicians and to receive more descriptive/informative information about their disease (Roter and Hall, 2006).

From a gender perspective, women are more likely to admit for health care, are better able to communicate by asking more questions in their communication with physicians, and are better informed about their illnesses. Women's general tendency to empathize more and their reluctance in conveying their feelings/thoughts is considered an important factor in this regard (Roter and Hall, 2006). Female doctors visit patients more frequently, behave more courageously, associate more, and sympathize more female physicians more conversational than male physicians and had a more patient-centered approach (Mast and Kadji, 2018).

The most recent literature review examining socio-economic differences in patient-physician communication was conducted in 2012 and was limited to the concepts of education level, occupation and income. Rather, this study was focused on socio-economic and cultural factors affecting physician-patient interaction.

Only few studies have been conducted so far on factors that affect physician-patient interaction in the area of this study. Kassim (2018) did a descriptive cross-sectional study on patient satisfaction focused on outpatient department case in Haramaya general hospital. The study focused mainly on waiting time, cost of treatment and how the level of patient satisfaction could be managed by physicians and also the hospitals management team member. However, not much has been documented in the study as it related with socio-economic and cultural factors that affect physician-patient interaction as outcome of health care service in the area of this study from the point of view of the patients themselves.

The connection between a doctor and patient might be anything from a cursory conversation between two complete strangers to a deep, emotional engagement between two individuals who are well acquainted. There is a claim that a clinical encounter is more than just the two-way conversation needed to share information. Instead, it is the result of how patients' lives and doctors' mental processes are shaped by an illness that occurs in each of their distinct situations (Sharma, 2012). Furber (2010) asserts that open communication between the physicians and patients is essential to disclosing medical information and reducing misunderstandings. Furthermore, the research on how physician peer effects and patient behavioral incentives might improve HIV/AIDS care and promote treatment adherence demonstrates how a doctor's manner and style influence a patient's interaction with them (Daniel, 2017).

2.2. Socio-economic and Cultural Factors Affecting Physician-Patient Interaction

2.2.1. Socio-economic factors affecting physician-patient interaction

Family role

A study on the significance of "family time-outs" during consultations found that family is a significant factor in the interactions between doctors and patients (Korfage, 2013). Friends and family can have an impact on how a doctor and patient communicate and make decisions together (Mitchell, 2012). It was important for many patients who belonged to ethnic minorities that their doctor showed interest for their family's welfare, spoke with them when they tried to build trust in their connection (Julliard, 2008). Patients sometimes reveal secret worries and fears to physicians that they have not yet disclosed to friends or family members. The doctors often missed this important contextual issue because they were used to focusing their interactions on the individual patient rather than the family Butow *et al* (2016). Additionally, studies on the emotional expression of patients from ethnic minorities during primary care consultations show that family relationships, culture, and values play a crucial role in the lives of these patients, and that the environment of their community has a direct impact on the illnesses of these patients (Deveugele *et al*, 2011).

Religion

The physician-patient interaction is also affected by religious status. Patients appreciate doctors who could accommodate their religious convictions, they also felt more at ease and confident when their doctors respect their individuality and fostered a culture of respect and interest. In line with this, a study conducted at Hawassa University Teaching Hospital on patient satisfaction with outpatient health services found that honoring patients' religious beliefs is a significant factor in determining how satisfied patients are with hospital care (Asefa and Rebecca 2014).

Marital Status

In comparison to married respondents, single respondents' satisfaction scores decreased on average in a cross-sectional study on factors influencing patients' satisfaction with interactions at central Ethiopian health institutions Birhanu *et al* (2010). In health care system, interactions between physicians and patients that involve empathy, and trust, influence patient satisfaction. There is also a significant positive correlation between patient-physician interaction and the patient's marital status (divorced) (Lan and Yan, 2017).

Gender of Physicians

The effectiveness of a doctor's gender in communicating with a patient is a topic of discussion in current research. Sex of the physician and sex of the patient as well as the sex composition of the physician-patient dyad affects how both physicians and patients behave during the medical interaction and it affects the quality of the interaction and its outcomes. Consequently, it is said that doctors who are female have a more patient-focused style. It has been found that female doctors visit patients more frequently, behave more courageously, associate more, and sympathize more female physicians more conversational than male physicians and had a more patient-centered approach (Mast and Kadji, 2018).

Income

In a cross-sectional study, the impact of patients' income level on the doctors' discussion of health risk behaviors was examined in connection to social class, control perception, and social justification. For example, when it comes to patients who were at risk, doctors discussed nutrition and exercise more with high-income patients and smoking more with low-income patients Kraus *et al.*(2009). Patients with more earnings were able to have more biomedical conversations compared to patients with incomes between medium and lower, or patients with higher levels of education. On the other hand, doctors were more likely to provide psychosocial counseling and education to high- and medium-income patients than to low-income patients (Jensen *et al*; 2015).

Education

Patients with greater incomes and higher educational levels also have more proactive behavior, ask more questions and give information to the doctors without being asked. Patients with better educational level and higher socioeconomic background are known to be more in contact with physicians and to receive more descriptive/informative information about their disease (Roter and Hall, 2006). Patients with a lower educational level are doubly disadvantaged because of their more passive communicative style and the physicians' misperception of their desire and need for information. However, the patient's inquiring, expressiveness, and willingness to share opinions were all helpful in the patient's ability to provide information. The physicians provide more information because of the patient's enhanced effective expressiveness and assertiveness, which are highly connected with their educational achievement (Laender *et al.*, 2012).

Occupational status

The natures of respondents' job affect physician-patient interaction. For instance, a cross-sectional study on patient satisfaction with tuberculosis treatment services and adherence to treatment carried out at a public health facility in the Sidama zone of South Ethiopia, there is a significant correlation between patient satisfaction and occupational status during medical interactions. Respondents' low socioeconomic status affects their interaction and decision making process. Additionally, physicians believed that they paid more attention to, examined and explained more to patients in higher social classes than those in lower social classes (Jalil *et al*, 2017).

2.2.2. Cultural factors affecting physician-patient interaction

Culture is made up of a people's unique customs. Culture involves guiding a group of people toward a shared goal and serves as a unifying force. Although people have a wide variety of habits, the genera of culture can be determined by examining the unique behaviors of a certain group of people. It is a common set of beliefs and actions among a community. Our lives are profoundly affected by our cultural heritages, and culture broadens the scope of the human experience. Culture affects health in many different ways. A person's cultural perspectives affect how they perceive and define health and illness, as well as how they respond to disease, suffering and disability (Ritzer, 2009).

Social Values

Understanding a patient's norms and values is determinant factors that affect physician-patient interaction in health care system. For example, although some value repressing expressions of sorrow highly, others genuinely support them. A cross-sectional mixed method study on patient satisfaction with doctor-patient interactions found that doctors should consider factors such as family values, religious beliefs, and school obligations when examining patients in the context of ongoing negotiations with the environment and history. By doing so, they are able to see themselves as regular people attempting to solve universal problems (Jalil *et al*., 2017).

Social Norms

Social norms influence the expected connections between patients and medical staff in hospital settings. Healthcare professionals are motivated to strike a balance between perceived patient

happiness and clinical appropriateness. From the patient's point of view, the wish to recover could be associated with a false belief that the best, quickest and most comprehensive response can be obtained with medication assistance (Hart *et al*, 2006).

Social norms have an impact on how patients and doctors interact, which in turn affects how patients view the prescription process. Perceived social roles are usually associated with an individual's specific situational expectations, habits, and social norms regarding behavior. The behaviors and perceptions of both parties are influenced by preexisting mental models and knowledge that defines appropriate conducts in various social contexts especially mores (Grimes, 2012).

Perception of care

In patient- physician interaction, patients have a common expectation that they would have an ailment that is symptomatic enough to warrant a visit to the doctor and a prescription for medication. Respondents perception of care and view of health and wellness have significant impact on the interaction process where having good view for once health have better chance to have good interaction and this shown in that respondents perceive the care received in the hospital. Physicians' scientific understanding of certain disease techniques is also a component in this and is seen to be a possible distraction from positive physician-patient interactions. For example, a cross-sectional mixed methods study on patient satisfaction in doctor-patient interactions discovered that developing expression management skills can make doctors more tolerant of working with patients who are illiterate and from low-income backgrounds, enabling them to provide services that live up to patients' expectations (Jalil *et al*., 2017).

View of health and wellness

Despite increased interest in physician wellness, little is known about patients' views on the physician-patient interaction. We explore patients' perceptions of physician wellness and how it links to patient care. Three overarching premises were identified in the study. First, patients notice cues that they interpret as signs of physician wellness. These include overt indicators, such as a physician's physical appearance, along with a general impression about a physician's wellness. Second, patients form judgments based on what they notice, and these judgments affect patients' views about their care; feelings, such as trust, in their interactions with physicians; and

actions, such as following care plans. Third, participants perceive a bi-directional link between physician wellness and patient care.

Physician wellness impacts patient care, but physician wellness is also impacted by the care they provide and the challenges they face within the healthcare system. Patients' judgments regarding physician wellness may have important impacts on the doctor-patient relationship. Furthermore, patients appear to have a nuanced understanding about how physicians' work may put physicians at risk for being unwell. Patients may be powerful allies in supporting physician wellness initiatives focused on the shared responsibility of individual physicians, the medical profession, and healthcare organizations.

For instance, studies on shame in doctor-patient interactions conducted by Harris et al. (2009), there is a strong correlation between doctors' awareness of patients' present ideas about illness and the benefits of disease on their health. Furthermore, based on an examination of patient satisfaction with doctor-patient interactions using a cross-sectional mixed technique, doctors who actively seek out from the viewpoint of the patient throughout the interaction and who aware how their own beliefs and values may influence the interaction, diagnosis, treatment, and outcome have positive patient relationships and significantly boost patient satisfaction (Jalil *et al*., 2017).

2.3. Theoretical Framework

Sick role and social action theories provided the theoretical guide for explaining outcome of the use of health care in terms of physician-patient interaction with health care services. The combination of perspectives, assumes that people have abilities and are capable of subjective evaluation. Talcott Parsons advanced Sick role model which emphasis the social dimension of illness (sick role) and social expectations.

In applying the theory to the users of health care services and in the role of patients, the individual who is sick (patient) and members of the public also, enter into a social relationship with the medical and health professionals-(physicians). Thus the application sees the pattern of behavior characteristics of the sick persons during illness management such as willingness to use and continue with the use of tertiary health care services, the assessment or evaluation of health care received and readiness to recommend to other people as determined within the context of social and cultural norms, beliefs and values of the people. Owumi, (2012) noted that there is an

inextricable relationship between socio-economic and –cultural factors in the use and non-use of health care services in illness management. A major expectation concerning the sick individual in our society is to seek health care services and advice and also co-operate with the professionals. According to Parsons, patients, doctor and nurses are acting out prescribed roles.

According to the theory, the role of the sick person is deemed to be undesirable; patients are expected to want to get better, to voluntarily seek professional health advice and cooperate fully with the doctor. By engaging in illness management, with the behavior of acceptance and cooperation in using the health care services s/he becomes involved with the role of the professional Doctors in a complementary but asymmetrical role relationship as one of compliance with expected norms.

The roles of the patients/doctor are also characterized by rights and expectations. Doctors are expected to use their skills and expertise for the benefits of their patients. In the performance of their duties they have the right to conduct physical examinations and ask patients question about their physical health and personal circumstance. Health care services (Hospital Services) in the teaching hospitals are oriented towards a supportive/creative notion of patient welfare. The sick or injured persons, following admission into the different wards are organized into various patient categories namely (emergency, medical, surgery, ophthalmic, hematology, neurology, orthopedics, urology, pediatrics, maternity/obstetrics and gynecology and psychiatrics). Thus this organization reflects the medical staff definition of their illnesses.

Max Weber proposed the use of subjective method as a means of understanding causal relationship behind action and reactions. According to Weber, Social action is an action which takes place when the acting individual attaches a subjective meaning to it (Haralambos and Holborn 2008; Olutayo and Akanle 2013). The theory is based on the understanding that the social exchange of action is only possible when interpretative understanding takes place, which of course, occurs when the parties involved ascribe meaning to each other's action. This implies that a patient would take health related action such as cooperation and acceptance of health related instructions in interactions with doctors, undressing for physical examination, acceptance of drugs/treatment administered and the food served in the context of present analysis, when the patient understand the action of the health professionals by interpreting the action provision of care services) and attaching meaning. Their interpretation, subjective meaning and understanding

of action produce a willingness to continue to reuse or discontinue with using the hospital as outcome of their subjective evaluation. The patient/care givers ascribe meaning to the different activities of care provisions by the medical and health care professionals which were oriented to bring about better health in the patient's life who is admitted into the hospital. Weber believed that the set of ultimate ends for which actor could strive was potentially infinite. Human beings act to achieve goals in situations to solve problems that confront them at any time.

The position of this Social Action theory which focuses on the individual's subjective assessment/evaluation of the outcome of health care especially with regards to using health care services through physician-patient interaction in the hospital is interpretative understanding, meaning and subjective judgment in human action social order and survival and maintenance of the society would be achieved. Their cooperation with doctors (interpersonal relationship) and compliance with treatment regimen are all subjective actions. In the same way, actions taken by the healthcare providers are forms of rational actions by a segment of the society and are all undertaken in accordance with shared value and normative dictates (Isiugo-Abanihe, 2002). Weber's social action theory tends to suggest that human actions can be explained as subjective behavior. Thus the patient, following the use the facility may express satisfaction with the health care services received from the professionals therein in their designated service areas as they contribute to patient care.

2.4. Conceptual Framework

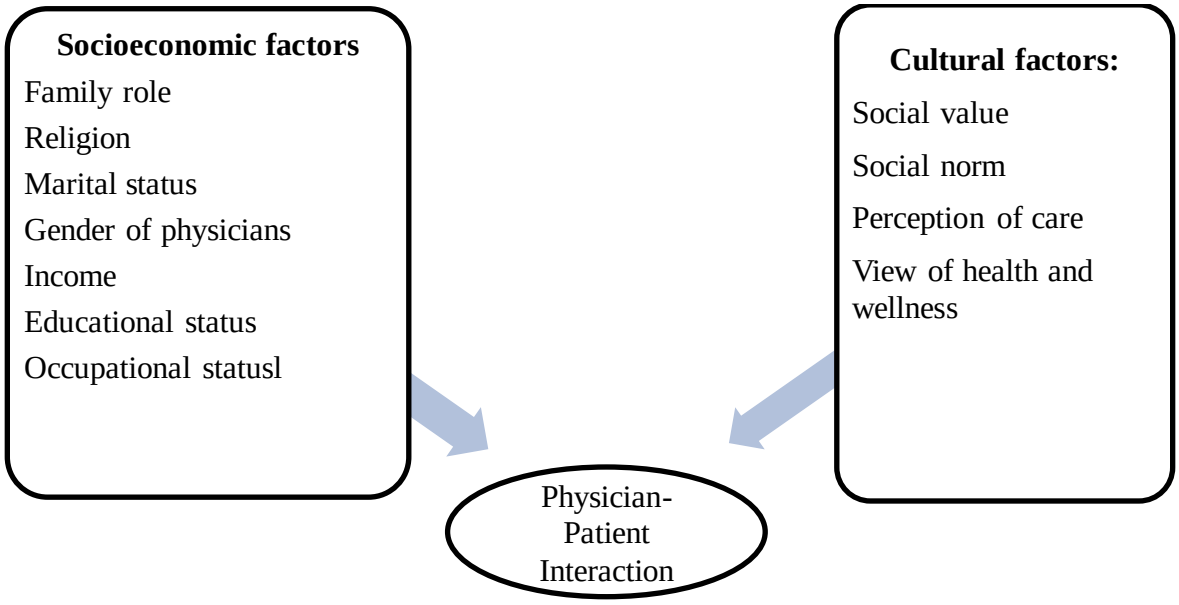

Figure 1. Conceptual frame work of the study

Sources: Developed by researcher from review of related literature

Through a survey of relevant literature used in this study, the conceptual framework for this investigation was constructed. Planning the research methods, establishing objective of the study, and preparing the instruments all depend heavily on this conceptual framework. This research was therefore predicated on the knowledge that cultural and socioeconomic variables influence patient-physician interactions in healthcare. The way patients and their physicians interact in the context of medical care is influenced by a number of factors. Social values, social norms, perceptions of care, views of health and wellness are examples of cultural factors that influence physician-patient interaction in medical care. The socio-economic factors that influence the interaction between patients and their physicians include the role of family, religion, healthcare professionals' gender, educational attainment, occupation, and income level (Jalil, 2017; Butow, 2016; Birhanu *et al*., 2010).

3. RESEARCH METHODS

3.1. Description of the Study Area

Haramaya is 2047 meters above sea level and is located at 90 24'N 42 01'E, or 9.4000 N 42.0170E (Philip Briggs (2009). It is located on the way to Dire Dawa, 10 kilometers west of Harar. It is situated near Lake Haramaya, a seasonal freshwater lake that is home to a flamingo population in addition to various birds and a variety of other crops. This study was carried out to assess socio-economic and cultural factors affecting physician-patient interaction in Haramaya General Hospital, Maya City, Oromia National Regional State.

The hospital serves many residents of Maya City as well as those from several districts in the east and west Hararghe zones as a teaching and referral facility. The hospital comprises many departments, including the maternity, X-ray, delivery, emergency care, neonatal-ICU (intensive care unit), outpatient department and ward for medicine and surgery. In the year of 2023, the hospital treated 9500 inpatients in a year (HMIS Report, 2023) from Haramaya general hospital.

3.2. Study Design

Descriptive cross-sectional study design was employed in this investigation. This design was chosen as it allows for selecting a relatively large number of people at one point in time. Besides, descriptive design enables to make an in-depth description of the issue under consideration.

3.3. Research Approach

This study was conducted through a mixed approach (both qualitative and quantitative approaches) as it is important to have a general picture of the issue under consideration and to minimize the weakness of each of the approaches.

3.3.1 Qualitative approach

This approach was chosen for this study, because it is good for open ended questions and describe in depth oral question and it has a lot of flexibility. The qualitative data were collected from inpatients and physicians for this study through in-depth and key informant interview tools of data collection.

3.3.2 Quantitative approach

The researcher employed a quantitative research approach to compare various groups, categorize, code and interpret vast amounts of data for straightforward descriptive statistical analysis that is useful for quantifying the outcome. Quantitative data were generated for this study from the patients through the distribution of questionnaire.

3.4. Study Population

In-patients and physicians in Haramaya general hospital were the research populations. This study included patients aged over 18 years old and physicians of the hospital.

3.5. Sampling Methods and Sample size

3.5.1. Sampling technique

Non-probability sampling technique was used in the investigation. In light of this, in order to choose 384 respondents, purposive sampling technique was used to select participants for this study by focusing only on inpatient department case. According to HMIS report of 2023 from Haramaya general hospital, a total of 9500 in-patients were treated in a year.

3.5.2. Sample size determination

Yemane's formula (1967) was used to determine the sample size. The yearly in-patient flows of the year 2023 were 9500 inpatients based on data retrieved from Haramaya general hospital (HMIS report, 2023).

$n= N/ [(1+N (e)^{2}]$, $n= 9500/ (1+9500(0.05)^{2}]$, $n= 384$

Where n is the sample size, N is the size of the population, and e is the acceptable degree of inaccuracy with alpha set at 0.05.

One medical director and two members of the hospital management team were selected purposively for this study as they have roles in the management and daily activities of the hospital. Therefore, the study was employed on 387 participants as a total of sample respondents in this study.

3.6. Data sources

3.6.1. Primary source

Primary data was collected from in-patients, physicians, a medical director, and a member of the hospitals management team through questionnaires, in-depth interview and key informant interview.

3.6.2. Secondary source

Secondary data were gathered through an examination of related literature from various sources such as books, articles, internet and also by referring to medical bio or history of diseases from the file/ card room in the hospital setting.

3.7. Methods of Data Collection

3.7.1. Questionnaires

Questionnaires were prepared to collect data from 384 inpatients based on the objective of the study. Questionnaires included both close-ended and open-ended items to help and formulate pertinent questions regarding the variables influencing physician-patient interaction. The goal of the study, the elements in the questionnaire and the procedures for collecting the necessary data from participants were explained to respondents in order to ensure the integrity of the data, accuracy, consistency and clarity.

3.7.2. In-depth interview

In line with the objectives of the study, this method was used to collect qualitative data using open-ended questions from in-patients and physicians which did not fill in the questionnaire.

3.7.3. Key informant interview

Key informant interview was used to collect qualitative data from the medical director and two physicians of the hospital's management team as they have a great role on the issues of the study in this hospital setting.

3.8. Methods of Data Analysis

The quantitative data were analyzed in this study using descriptive statistics in the form of tables, frequency distribution and percent. The qualitative data obtained through key informant interview and in-depth interview were analyzed manually through careful interpretation of meaning based on the objective of the study.

3.9. Ethical Consideration

Informed consent was given by the respondents before their participation in the study. The study's objectives, procedures and benefits are described in detail by the researcher in their explanation. Participants were given thorough description of their voluntary participation in the study and their freedom to withdraw at any time. The guarantee was that any data gathered about the participants was treated in the strictest confidence and that their identities and private information won't be disclosed to third parties should be provided to participants.

4. RESULTS AND DISCUSSION

This part of the Thesis aims to provide the research findings, data analysis, and interpretation.

Since the study used both quantitative and qualitative data, this study was employed to explore the related socioeconomic and cultural factors affecting physician-patient interaction. The study also looked into the experiences of patients and how they interact with doctors in physician-patient interaction, and this was seen in relation to a theoretical framework/models, particularly activity-passivity and guidance co-operation models.

4.1. Socio-economic factors affecting physician-patient interaction

As shown from Table 1, for the statement that the importance of role of the family members to have good interaction with physician, most of the respondents about 250(65.1%) of them believed that family has important role in creating good interaction, whereas, about 134(34.9%) of the respondents believed that the role of family on forming good interaction was limited. The result shows that importance of the role of family was seen as on factor in forming good interaction which show that most of the respondents were from rural area in where there is strong collective conscience in which interdependence to one another is strong.

With regard to this, one interviewee female participant 20 years old, who were taking treatment in this hospital setting said: “some patients do not communicate well and make good decision making with health care providers unless family member and friends present with them in medication and so they make less contact, and low interaction with their physicians.” In similar to this, one KII told that “some patients cannot tell to health care providers a true history of their diseases and express their ideas independently. Especially, patients who are old in age, some youth patients, and those who are low in educational achievement cannot make good communication and participation in decision making process when examination and medical diagnosis practiced.” Thus, the result of this data concluded that, family member and friends play a significant role in physician-patient interaction in understanding what the physicians said during the medical diagnoses and prescription of medicine. In support to this idea, a study conducted by Mitchell (2012) shows, friends and family can have an impact on how a doctors and patients communicate and make decisions together.

The respondents distribution based on religious views as Table 2 shows, out of 384 total respondents, more than half about 200(52.08 %) of them were thought religious views has its own effect on physician-patient interaction while about 184(47.92%) of the respondents were not thought religious views as it has no effect in D-P interaction. The result implies that respondents felt valued with physicians who have aware or conscious, respect, and understood about their religious beliefs and customs in health care system. For instance, one interviewee male patient 28 years old, reported that: "due to the influence of religious status, some patients might worried in physician-patient interaction, they received less attention, they do not have good motivation to discuss with health care providers, and they believed that, physicians views and ideas are different to their views and ideas as differ in religious status." The result of this data shows, majority of respondents have low interaction, less contact with physicians and negatively affected in physician-patient interaction while taking medical treatment. In support to this idea, a study conducted by Rebecca (2014) shows that, patients appreciated doctors who could accommodate their religious convictions and fostered a culture of respect and interest.

The marital status distribution of respondents indicated that the single respondents constituted 62.5% while the married one about 144(37.5%) As seen in Table 3, the trend of marital status married respondents were demanding health service. Hence, majority of the respondents about 240(62.5%) of them were affected in physician-patient interaction due to their marital status while some about 144(37.5) of respondents did not. Among the respondents about 240 (62.5%) who affected due to their marital status, majority of them about 150 (39.06%) were single respondents while some only about 90 (23.44%) of them were married. Based on this result it can be concluded that the married (divorced) respondents had more medical interaction with healthcare providers than the single (unmarried) respondents. In addition to the above quantitative data result, the question for qualitative data also presented there "does your marital status affect your physician-patient interaction?" , one of KII told that marital status related factors affect physician-patient interaction, a man aged in 42 years old with a medical laboratory coordinator of the hospital said:

> Some respondents either male or female have not good interaction with physicians due to their marital status. They did not respond well the questions regarding their diseases and illness to health care providers properly because they have a psychological fear to tell all things about their problems as the physicians asked. There is also the problem of active participation in decision making process and express their ideas to health care providers. Majority of

> respondents who were single more frequently and negatively affected in physician-patient interaction and may leave without getting enough medical care from this hospital setting due to their marital status.

The results from both quantitative and qualitative data concluded that, married patients more conscious and interact more than the single patients. To support this finding, the findings conducted by Lan and Yan (2017) states that there is a substantial positive link between patients' marital status and their level of satisfaction in physician-patient interaction.

Respondents distribution based on gender disparity among physicians indicated that, most of the respondents about 260 (67.7%) of them thought gender of physicians refers to male or female affect physician-patient interaction whereas some about 124 (32.3%) of the respondents did not. It suggested that variations in gender among medical professionals affect how they interact with patients. It can be concluded that majority of respondents about 260 (67.7%) of them were affected due to gender of physicians while taking medical treatment. For instance, as interviewee participant, females, aged in 29 and 26 years old said:

> Female patients are worried in medical procedure and they do not have confidence, they also confused in examination and medical diagnosis in medical care, they do not tell their illness and diseases symptoms to health care providers as required. They faced the problems of less information and less counseling given by physicians concerned with their health problems due to difference in gender of physicians referred to female or male. And so some female patients cannot get enough medical treatment and negatively affected in physician-patient interaction.

According to research by Mast and Kadji (2018), female physicians have more patient centered approach, which is consistent with this result.

It is said that female doctors visit the patient more frequently, behave more courageously, associate more, and sympathize more. Generally, among the social factors, gender of the physicians was the major factor that negatively affects the interaction between patients and health care providers in this area of the study. This indicates that patients feel at ease when they are accompanied by the relatives during medical treatment.

The attributes of the in-patients concerning level of education reveal that respondents about 80(20.83%) of them were no formal education, about 196(51.04%) of them primary school, about 96 (25%) of them post primary, about 12(3.12%) of them were Degree and above. Hence, those who were not enrolled to school, who learn only primary school and negatively affected in

physician-patient interaction and less contact with their physicians than those who were post primary, Degree and above in educational achievement.

In line with this, the data from an in-depth interview also supported the results of this finding. Thus, one interviewee male participant aged in 43 years old said:

> When I come to this hospital there are different problems that I was faced during medical diagnosis and examination. I do not understand well what the physicians said when I examined and diagnosed, I cannot read the prescription of the medicine and missed the medicine. I could not back to the class where I examined first. Hence, I do not have good communication with health care providers and make less contact and low interaction because of my educational level is very low and negatively affected in physician-patient interaction.

Similarly, the data from KII also reported that:" some respondents could not understood what the physicians told to them accordingly, some of them did not take the medicine as physicians stated in prescription of the medicine, Some respondents were not carefully listen their physicians while taking the treatment in this hospital setting. These problems might be happened as a result of their educational status and negatively affected in physician-patient interaction".

Data on distribution of the respondents by occupational status indicate that out of 384 total respondents, about 167(43.5%) of respondents were daily laborer, about 130(33.9%) of them were farmer, about 62(16%) of them were merchants, about 25(6.5%) of respondents are public employee. Based on the result, it concluded that, majority of respondents who are low in occupational status less contact and have low interaction with their physicians in medical care when compared to the higher occupational level. To support this finding, a study by Jalil *et al*. (2017) provides evidence in favor of this, showing a significant relationship between the way patients and doctors interact and the occupational status of the respondents.

The respondents distribution based on their income status shows that among the total respondents 384, about 220 (57.3%) of respondents got less than 400(ETB) per month, about 110(28.64%) of them got 4000-5000(ETB), about 54 (14.06%) of them constitute > 5000(ETB) per month. From the result it concluded that, the socioeconomic characteristics of the respondents' shows that income status was low in this hospital setting. Hence, majority of respondents were negatively affected in physician-patient interaction in this area of the study.

4.1.1. Family Role

Table 1: Respondents' family role

Variable	Categories	Frequency	Percent
Do you think the role of family member is important to have good interaction with the physician?	Yes	250	65.1%
	No	134	34.9%
Total		384	100%

Source: Survey, 2024

4.1.2. Religion

Table 2: Respondents distribution based on religious views

Variable	Categories	Frequency	Percent
Do you think that a religious view has affect physician-patient interaction in medical care?	Yes	200	52.08%
	No	184	47.92%
Total		384	100%

Source: Survey, 2024

4.1.3. Marital status

The marital status of the respondent represented their relationship status at the time of the study's survey. In the context of doctor-patient interaction, it refers to the degree of relationship.

Table 3: Respondents distribution based on marital status

Variable	Categories	Frequency	Percent
Marital status	Single	240	62.5%
	Married	144	37.5%
Total		384	100%

Source: Survey, 2024

4.1.4. Gender of Physicians

Table 4: Respondents distribution based on gender of physicians

Variable	Categories	Frequency	Percent
Do you think that gender of physicians refers to female or male affect your interaction**?**	Yes	260	67.7%
	No	124	32.3%
Total		384	100%

Source: Survey, 2024

4.1.5. Education

Table 5: Respondents distribution based on educational status

Variable	Categories	Frequency	Percent
Educational status	No formal education	80	20.83%
	Primary School	196	51.04%
	Post primary	96	25%
	Degree and above	12	3.12%
Total		384	100%

Source: Survey, 2024

4.1.6. Occupation

Occupational level is one of the determinant factors that influence the interaction between physicians and patients.

Table 6: Respondents occupational status

Variable	Categories	Frequency	Percent
Occupational status	Daily laborer	167	43.5%
	Farmer	130	33.9%
	Merchant	62	16%
	Public employee	25	6.5%

Source: Survey, 2024

4.1.7. Income

Table 7: Respondents distribution based on income status

Variable	Categories	Frequency	Percent
Income status	< 4000(ETB)	220	57.3%
	4000-5000(ETB)	110	28.64%
	>5000(ETB)	54	14.06%
Total		384	100%

Source: Survey, 2024

4.2. Cultural Factors Affecting Physician-patient Interaction

As indicated from Table 8, considering value attached to health, more than half about 200 (52.08%) of respondents their physician did not consider the value they have for health, but for some 184(47.92%) of them feel that their physician had considered the value they have attached to their health. For example, According to one interviewee participant who are 29 years old told that" some respondents did not accept and follow the physicians' advice properly because of the pressure of their religious status and so majority of respondents were negatively affected in physician-patient interaction". For instance, a descriptive cross-sectional mixed methods study on patient satisfaction with doctor-patient interactions found that, doctors should consider factors such as family values, religious beliefs, respect and school obligation when examining patients in the context of ongoing negotiation with the environment and history (Jalil *et al*., 2017).

Respondents distribution based on norm attached to health As seen in Table 9 indicated, being able to understand patient norm was other factor where for most about 301(78.4%) of the respondents feel that the treatment they received in line with their norm, but for some about 83(21.6%) of the respondents feel that the treatment they received did not go in line with their norm. To support the results of this finding, data from one interviewee concluded that "social norms have an impact on how patients and doctors interact, especially how patients view the prescription process, and their specific situational expectations like shame, fear of male physicians are the major factors that negatively affect the physician-patient interaction". Similarly, according to one of KII and in-depth-interviewee participants suggested that "

> Some respondents do not express their illness and the problem of their diseases, especially medical history of their diseases to health care providers accordingly. Some of them were also leave from this hospital without proper medical examination because of their expectation concerned to social norm and so some female patients were more affected than male patients in physician-patient interaction as a result of their expectation concerned to social norm related to health care system in this hospital setting.

Based on the results, from both quantitative and qualitative data, it concluded that, majority of respondents were negatively affected in physician-patient interaction due to the influence of social norm attached to health.

As respondents distribution based on their own perception of care in Table 10 shows, most of them about 264(64.06%) feel that their perception of care had affected in patient-physician interaction whereas some about 138(35.94%) did not. Besides to this, as one interviewee participants through an in-depth interview said:

> Patients have their own common expectations on a disease or sickness that is symptomatic enough either to defend or confirm a visit to the doctor and a prescription for medication. In addition, another interviewee reported physicians' scientific understanding of certain disease techniques is also a component in this and is seen to be a possible distraction from positive physician-patient interactions. The problems of perception of care from some health care providers and the patient themselves were the major factors that affecting physician-patient interaction in the study.

As seen in Table 11, most of the respondents about 270 (70.3%) of them feel that their physician had understood their view on health and wellness whereas some about114 (29.7%) of the respondents they did not feel that their physician understood their view of health and wellness. It implies that, some of the respondents were negatively affected in physician-patient interaction because of low physicians view on health and wellness to their patients.

In line with this a study conducted by Jalil *et al., (2017)* found that, doctors who actively seek out from the viewpoint of the patient throughout the interaction and who are aware how their own beliefs and values may influence the interaction and diagnosis, the outcome would significantly boost patient satisfaction.

4.2.1. Value

Table 8: Respondents' social values

Variable	Categories	Frequency	Percent
Do you think your physician treat you by considering your health value?	Yes	184	47.92%
	No	200	52.08%
Total		384	100%

Source: Survey, 2024

4.2.2. Norm

Table 9: The influence of social norm

Variable	Categories	Frequency	Percent
Do you think that your physicians' way of providing treatment is acceptable in your norm?	Yes	301	78.4%
	No	83	21.6%
Total		384	100%

Source: Survey, 2024

4.2.3. Perception of care

Table 10: Respondents perception of care

Variable	Categories	Frequency	Percent
Do you think that your perception of care affected your interaction with the physician?	Yes	264	64.06%
	No	138	35.94%
Total			100%

Source: Survey, 2024

4.2.4. View of health and wellness

Table 11: Physicians view of health and wellness

Variable	Categories	Frequency	Percent
Did you think your physician had understood your view on health and wellness	Yes	270	70.3%
	No	114	29.7%
Total		384	100%

5. SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter includes a summary of the investigation and the conclusions drawn from its findings. Finally, recommendations were forwarded.

5.1. Summary

The relationship between a doctor and patient is fundamental in medical profession and is necessary for providing excellent healthcare for the diagnosis and treatment illnesses. This study was conducted in Haramaya general hospital, Maya City, Oromia National Regional State. The study examined the socioeconomic and cultural factors affecting physician-patient interaction in medical care. A descriptive cross-sectional study design was used in the study. Semi-structured questionnaires, in-depth and key in formant interview were used for the study as instruments of data collection tools and the data was collected through both quantitative and qualitative approaches. Semi-structured questionnaires were used to collect quantitative data, while key informant and in-depth- interview to qualitative data. The quantitative data were analyzed using descriptive statistics in the form of tables, frequency distribution and percent. Qualitative data were analyzed through careful interpretation of meaning based on the objective of the study. Purposive sampling technique was used to select the sample frame of participants by focusing on only inpatient department case. The study found that patients' interaction with their physicians influenced by a number of socioeconomic and cultural factors. Family role, religion, marital status, gender of physicians, educational status, income and occupational status were the determinant socio-economic factors that affect physician-patient interaction in the study. and also social values, social norm, perception of care, view of health and wellness were considered the cultural factors that affect physician-patient interaction in the study. The study found that the role of family and friends have a significant effect on physician-patient interaction in medical diagnoses and examination procedure. From the result of the finding, majority of respondents were affected in physician-patient interaction due to their socioeconomic status, perception of care, view of health and wellness when medical diagnoses and examination has practiced in medication. Respondents who have low in their socioeconomic status, low perception of care, and view of health and wellness negatively affected in physician-patient interaction than those who are high in their socio-economic status.

5.2. Conclusion

This study tried to assess how socioeconomic and cultural factors affect physician-patient interaction in Haramaya general hospital, Maya City, Oromia National Regional State. The study specifically explored how these factors affect the perceived level of interaction by the patient and the way patients perceive the behavior of the physician. Concerning to this understanding the socioeconomic and cultural factors in health care delivery system enables to incorporate this factor in in line with the biomedical aspect of health and medicine. However, the study found that experiencing good interaction was influenced by a number of socioeconomic and cultural factors. Based on the finding of the study, individuals without formal education were having low interaction with their physician. This necessitates to rely on the support of their family member to help them in the process of interaction, allowing the family member in to participate in the interaction process have its own impact for this individuals chance of having good interaction. The study found that gender disparity among physicians the other factor negatively influenced the interaction process.

Patients of low socioeconomic status receive fewer preventive services, worse diabetes care and less contact with their physicians and frequently affected in medication. As concluded from the finding, majority of respondents were affected in physician-patient interaction as a result of their socioeconomic status and thus most subjects within the study states that respondents' socioeconomic status influenced the health care they received. Majority of them had difficulty expressing or were reluctant to say that their own personal health care may inferior because of their socioeconomic status. On other hand, physicians information giving was positively influenced by the patients interaction style such as question asking, affective expressiveness and independently opinion giving. More affective expressiveness and being assertive on the patients side which is strongly related to his or her educational level leads to more information giving on the doctors' side. Finally, patient-physician interaction was also affected in the study by some cultural factors related to health. Patients could make more contact and interact with physicians who understood, respect and aware about their values, norms, and view of health and wellness attached to health. Hence, based on the results of the finding, majority of respondents were negatively affected in physician-patient interaction.

5.3. Recommendations

Based on the findings of the study, the following recommendations are forwarded;-

Physician-patient interaction is affected in medical care by different socioeconomic and cultural factors. Majority of patients were affected in the interaction due to the absence of their family and friends. Unless family members and friends present with them, majority of them have low contact and less interact with health care providers. Hence, physicians and all health care providers should give awareness and encourage them while giving the treatment as they make confidence and talk free opinions independently. Majority of respondents were also affected in physician-patient interaction due to their religious status, marital status, and difference in gender of physicians. Thus, in order to reduce these problems, effective training and awareness should be given for patients and health care providers by medical director of the hospital and other health stakeholders.

Due to socioeconomic factors like educational achievement, occupational, and income status majority of respondents were affected in physician-patient interaction. Patients who are low in educational achievement, occupational, and income status were frequently affected in their interaction with physicians and had less contact with health care providers. Therefore, health stakeholders either governmental or non- governmental organizations should solve these problems by giving psychosocial support and counseling for patients who are taking treatments in this hospital setting and also for members of the community who are living out of this hospital through making partnership with medical director of the hospital, management team members, health care providers, and other concerned bodies.

Among cultural factors social values and norms, perception of care, view of health and wellness are the major ones that affecting physician-patient interaction in this study. As the finding of the study indicates, majority of respondents were affected in physician-patient interaction due to the physicians ability to understand, respect, and aware about these factor. Thus, these problems should be solved by creating awareness and giving training for the community by social workers, NGOs, and all responsible government organization particularly in Maya City like, health office, and other clinicians. Above all, physicians should create an opportunity for patients to participate in decision making process and also patients should properly follow their physicians and prescriptions accordingly.

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7. APPENDICES

APPENDIX I

HARAMAYA UNIVERSITY

COLLEGE OF SOCIAL SCIENCES AND HUMANITIES

DEPARTMENT OF SOCIOLOGY

Participants Information Sheet

The purpose of this study is to ask respondents who are inpatients at Haramaya General Hospital about the socioeconomic and cultural aspects that affect the physician-patient interactions.

Dear respondent, I would like to inform you that this question is for academic purpose only, which is to collect information for MA Thesis at Haramaya University, College of social sciences and humanities in department of sociology. The results of this investigation could be useful in understanding the factors that affect physician-patient interactions in the research area.

As the patients of this hospital your views and ideas were considered very important for the success of the study and it would very much appreciated if you spend a little time to answer this question.

Name_____

Age_____

Sex_____

Level of education_____

Date_____

Place_____

Part one: demographic characteristics of respondents

1. Age: A. 18-25 B. 26-40 C. 41-60 D. 60 and above

2. Sex: A. Male B. Female

3. Relationship status: A. Single B. Married

Part two: Questions related to socioeconomic factors affecting physician-patient interaction

4. Do you think that your physician-patient interaction is affected because of your economic background?

A. Yes B. No

5. Are you affected in physician-patient interaction as a result of your income status?

6. If yes, what is your level of income?

7. Does educational status affect your physician-patient interaction? A. Yes B. No

8. What is your level of education?

9. Do you affected in physician-patient interaction due to occupational status? A. Yes B. No

10. What type of your jobs?

11. Do you affected in physician-patient interaction due to income status? A. Yes B. No

12. If yes what is your income status?

13. Do you think the role of family member is important to have good interaction with the physician?

A. Yes B. No

14. If yes how? _____

Part three: Questions related to socio-cultural factors affecting physician-patient interaction

15. Do you have any barrier with your doctor when you were diagnosed? A. Yes B. No

16. Do you think that your physicians' way of providing treatment is acceptable in your norm?
A. Yes B. No

17. If your answer Q. No 16 is yes, how_____

18. Do you think your physicians treat you by considering your health value?

A. Yes B. No

19. Do you think that your perception of care affected your interaction with the physician?

A. Yes B. No

20. Did you think your physician had understood your view on health and wellness?

A. Yes B. No

21. If your answer is No, to the above Q. No 17 how your view attached to health were affected?

_____

_____

Thank you!!

APPENDIX II

HARAMAYA UNIVERSITY

COLLEGE OF SOCIAL SCIENCES AND HUMANITIES

DEPARTMENT OF SOCIOLOGY

In-depth interview questions

This is interview questions on the socio-economic and cultural factors affecting physician-patient interaction in Haramaya general hospital to be answered by respondents in this area of the study.

Dear respondent, I would like to inform you that this question is for academic purpose only, who is to collect information for MA Thesis in Haramaya University, College of social sciences and humanities in department of sociology. The outcomes of this study may help to know the factors affecting physician-patient interaction in medical care in this hospital setting.

Thank you for taking the time to answer this question. Your opinions and thoughts were valued highly as one of the respondents and were thought to be crucial to the study's success.

Part I: Background information of the respondents

Name_____

Age_____

Sex_____

Educational level_____

Part II: Interview guide question on factors affecting physician-patient interaction

1. How was the relationship between you and your doctor when medical diagnosis has been practiced?

   _____

   _____

2. What are the factors affecting the interaction between you and your doctor in medical care?

   _____

3. Do you believe that the interaction between you and your doctor was affected by socio-economic and cultural factors in this hospital setting while diagnosed?

   _____

4. What are the socio-economic factors affecting the interaction between you and your physicians in health care system in this area of the study? _____
5. How educational status is affect your physician-patient interaction?_____

   _____

6. Do you think that your physician-patient interaction was affected because of your economic background? _____

   How was the role of family in physician-patient interaction in this hospital?_____

7. What were socio-cultural factors affecting physician-patient interaction in this hospital setting while medical diagnosed? _____

APPENDIX III

HARAMAYA UNIVERSITY

COLLEGE OF SOCIAL SCIENCES AND HUMANITIES

DEPARTMENT OF SOCIOLOGY

Interview Questions for Key informant

This is interview questions on the socio-economic and cultural factors affecting physician-patient interaction in Haramaya general hospital to be answered by key informant in this area of the study.

Dear respondent, I would like to inform you that this question is for academic purpose only, who is to collect information for MA Thesis in the Haramaya University, College of social sciences and humanities in department of sociology. The outcomes of this study may help to know the factors affecting physician-patient interaction in medical care in this hospital setting.

Thank you for taking the time to answer this question. Your opinions and thoughts were valued highly as one of the respondents and were thought to be crucial to the study's success.

Part I: Background information

Name:-_____

Sex:-_____

Age:-_____

Total years of experience:-_____

Part II: Guiding interview questions for key informant

1. How do you see the interaction between physicians and patients in this hospital setting? _____
2. What are the major problems that patients face when they encounter with their physicians in this hospital while diagnosed? _____
3. How do you see the problems that affect physician-patient interaction in your hospital setting while medical care treatment has been practiced? _____
4. What are the socio-economic and cultural factors affecting physician-patient interaction? _____
5. How was the physicians and patients' perception of care that affects physician-patient interaction in your hospital setting? _____
6. What look like the patients and physicians view of health and wellness that affects the interaction between physicians and patients in this hospital setting? _____
7. How physicians' professional years of experience were affected physician-patient interaction in this area of the study? _____
8. Generally, how these problems could be overcome? _____

Thank you!!