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Research Article

Strategies to Enhance Doctor-Inpatient Communication in a Tertiary Care Hospital, Bahawalpur, Pakistan: a Qualitative Study

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ABSTRACT
Objective: This study primarily aimed to explore and compare strategies to effective communication between doctors and inpatients in a tertiary care hospital in Bahawalpur, Pakistan. This study also identified common and divergent strategies proposed by the stakeholders and generated contextually informed recommendations for bridging the communication gap between the doctor-inpatient relationships in a tertiary care setting.
Study Design and Setting: A qualitative, exploratory inquiry was conducted in the medical ward of Bahawal Victoria Hospital, Bahawalpur, from August to September 2024.
Methodology: Semi-structured interviews were conducted with 10 purposively selected doctors and 10 inpatients. Interviews were audio-recorded, transcribed verbatim, and analyzed manually using Braun and Clarke's thematic analysis framework.
Results: Analysis yielded six themes from doctors and six themes from inpatients, reflecting solutions at individual, interpersonal, and systemic levels. Doctors emphasized language and cultural competence, communication training, patient education, structural support, safety, and multidisciplinary reforms. Inpatients highlighted enhanced availability, clear explanations, fairness, education, supportive environments, doctor's behavior, and systemic navigation support.
Conclusion: Implementing strategies targeting communication skills, patient engagement, institutional support, and systemic reforms could foster patient-centered, empathetic interactions and improve care quality in tertiary care hospitals.

Keywords: Communication Barriers, Health Communication, Inpatients, Patient Satisfaction, Physician-Patient Relations, Teach-Back Communication, Tertiary Care Centers, Tertiary Health Care.

INTRODUCTION

Doctor-patient communication is defined as "a consensual interaction in which the patient knowingly seeks the physician's assistance and in which the physician knowingly accepts the person as a patient."[1] A key factor in assessing healthcare quality is effective doctor-patient communication, which affects patient satisfaction, treatment adherence, and clinical outcomes worldwide. Up to 70% of adverse healthcare events worldwide are attributable to communication breakdowns, underscoring the importance of communication for patient safety and treatment quality.[2] Effective communication is even more important in inpatient settings since patients are emotionally fragile and reliant on constant information.[3] However, the international literature reports that effective doctor-patient interactions are hindered by temporal constraints, linguistic

discordance, and suboptimal communication skills, especially in resource-constrained health systems.[4,5]

High patient-to-doctor ratios, limited health literacy, and hierarchical medical cultures, as reported by several studies conducted throughout South Asia, further limit patient involvement in collaborative decision-making and communication.[6,7] Empirical evidence from regional studies indicates that consultation durations in public hospitals often last two to five minutes, which reduces the amount of time available for empathy and explanation.[8] Comparable problems are present at Pakistani tertiary care hospitals, which are compounded by multilingual patient populations, overcrowded wards, and a lack of formal training in communication skills.[9] There is a noticeable dearth of qualitative data examining stakeholder-driven solutions, particularly from inpatient contexts, even though the majority of Pakistani research to date has concentrated on identifying communication challenges, particularly in outpatient settings.[10]

Understanding how doctors and inpatients themselves propose to overcome communication challenges is essential for developing feasible, contextually relevant interventions. Therefore, this study aims to explore and compare solutions suggested by doctors and inpatients to improve doctor–inpatient communication in a tertiary care hospital setting.

METHODOLOGY

This exploratory qualitative study was conducted at a tertiary care teaching hospital in Bahawalpur, Pakistan, from September to November 2025, after approval from the institutional Review Board of National University of Medical Sciences (NUMS) (No: 06/IRB&EC/NUMS/11, dated 24/05/2024) and the Ethical Review Board of Quaid-e-Azam Medical College, Bahawalpur (IRB No: 5288/QAMC Bahawalpur, dated 10/07/2024). A qualitative approach was selected to gain an in-depth understanding of doctors' and inpatients' perspectives regarding feasible solutions to improve doctor–inpatient communication in an inpatient setting.

Participants were recruited voluntarily after obtaining written informed consent. The study population comprised two stakeholder groups: doctors working in the medical ward and inpatients admitted to the same ward. Purposive sampling was used to ensure inclusion of participants with direct experience of doctor–inpatient communication. Sampling continued until data saturation was achieved, defined as the point at which no new themes emerged from successive interviews. A total of 21 semi-structured interviews were conducted, including 10 doctors and 11 inpatients.

Inclusion Criteria

Doctors were included if they were actively involved in inpatient care in the medical ward, including faculty members and postgraduate residents. Inpatients were included if they were aged 18 years or older, had been admitted for at least 48 hours, and were able to communicate in Urdu, English, Saraiki, or Punjabi.

Exclusion Criteria

Patients who were critically ill, cognitively impaired, or unable to participate in an interview were excluded. Doctors not directly involved in inpatient care were also excluded.

Guided by the Deliberative Model of "Doctor–Patient Communication" by Emanuel and Emanuel and Social Cognitive Theory by Bandura, the study adopted a constructivist approach to explore shared decision-making, reciprocal communication, and behavior-shaping factors influencing proposed solutions by doctors and inpatients (Figure-1). Data was collected through semi-structured interviews using an interview guide developed from a literature review and refined through expert input. Each interview lasted for 20-25 minutes. Interviews were conducted in participants' preferred language, audio-recorded with permission, and later transcribed verbatim.

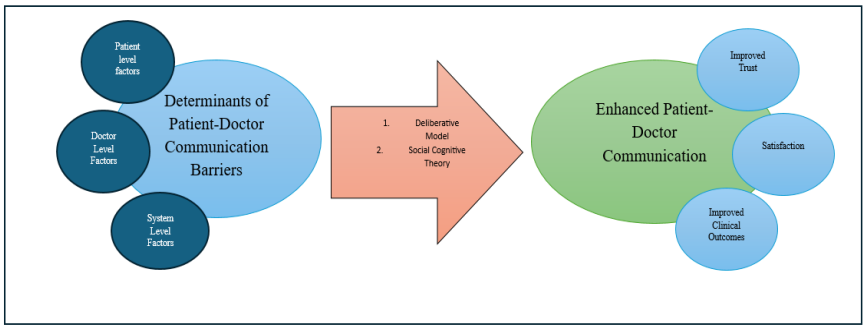

Figure- 1 Conceptual Framework: Deliberative Model and Social Cognitive Theory Guide Enhanced Patient-Doctor Communication

Data analysis was performed using Braun and Clarke's six-phase reflexive thematic analysis. An inductive approach was employed, whereby transcripts were read repeatedly to achieve familiarization, initial codes were generated as concepts became recognizable, and codes were grouped into subthemes and overarching themes focusing on communication improvement strategies. Coding was carried out manually, and themes were refined through iterative comparison with the raw data. Credibility and trustworthiness were ensured through member checking, peer debriefing, reflexive journaling, and maintenance of an audit trail. Confidentiality and anonymity were maintained throughout the study, and participants were informed of their right to withdraw at any stage without any consequences.

RESULTS

A diverse demographic profile of the study population is illustrated in Table I, which provides a comprehensive perspective on strategies proposed for enhancing the doctor-patient relationship.

Table I Demographic Profile of the Population

Characteristics		**N (%)**
Doctors (n=10)		
Gender	Male	6 (60%)
	Female	4 (40%)
Age (Years)	25–35	4 (40%)
	35-45	4 (40%)
	45-60	2 (20%)
Designation	Professor	1 (10%)
	Assistant Professor	1 (10%)
	Senior Registrar	3 (30%)
	3rd Year Resident	2 (20%)
	4th Year Resident	3(30%)
Locality	Bahawalpur	3 (30%)
	Other Cities	7 (70%)
Inpatients (n=10)		
Gender	Male	7 (70%)
	Female	3 (30%)
Age (Years)	35-40	2 (20%)
	40-50	4 (40%)
	50-60	4 (40%)
Level of Education	Graduated	2 (20%)
	Never attended	8 (80%)
Locality	Bahawalpur	3 (30%)
	Other Cities	7 (70%)

Twelve themes related to stakeholder-suggested solutions from 20 semi-structured interviews were identified, comprising six themes from doctors and six from inpatients. Themes were categorized into 28 subthemes, representing distinct strategies for improving

communication in tertiary care environments, as shown in Table II, and are explained in detail below.

Table II Themes and Subthemes of Stakeholder-Suggested Solutions to Improve Doctor–Inpatient Communication

Stakeholder	Themes	Subthemes
Strategies suggested by doctors	1. Language and Cultural Competence in Communication	Simplifying medical jargon Learning local dialects Using visual aids Respecting cultural and gender norms
	2. Communication Skills Training and Professional Development	Formal communication training Workshops Role-plays and simulations Integrating communication modules into the medical curriculum
	3. Patient Education and Participatory Engagement	Encouraging patient questions Tailoring explanations to the literacy level Using pictorial aids and demonstration Orientation of attendants
	4. Institutional Support for Effective Communication	Private counseling spaces Clear hospital navigation Structured counseling time Reducing workload Improving staffing
	5. Physician Safety and Occupational Well-Being	Implementing security measures Harassment policies Mental health support Regulating duty hours and breaks
	6. Interdisciplinary Collaboration and Systemic Reform	Teamwork with nurses and allied staff Institutional policies for fairness and ethical practice Improving staffing and resources
Strategies Suggested by In-Patients	1. Availability and Clarity in Clinical Communication	Allocate more time per patient Reduce doctors' workload Use simple, local language Check patient understanding
	2. Transparency, Accountability, and Patient Feedback	Transparent and fair practices Provide avenues for patient feedback and accountability
	3. Patient Education and Counseling	Tailored patient education Use a visual aid Repeat instructions for comprehension
	4. Supportive Care Environment and Family Engagement	Encourage patient questions Create a welcoming environment Involve family in communication and decision-making
	5. Professional Conduct and Empathetic Communication	Practice active listening Maintain eye contact Show empathy and respect
	6. Health System Navigation and Structural Support	Private, confidential consultation settings Facilitate patient navigation with support mechanisms

Strategies Suggested by Doctors

Theme-1: Language and Cultural Competence in Communication

Participants emphasized that improving language proficiency and cultural sensitivity is essential to overcome communication barriers with inpatients. They suggested that formal

training in local languages (Punjabi/Saraiki) would significantly enhance mutual understanding and build rapport.

(D4) "Our patients come from rural areas and speak their own dialects. We need basic training to understand and speak these languages; otherwise, communication will always be difficult."

In addition to linguistic competence, doctors also stressed the importance of cultural awareness. They expressed that understanding cultural norms, particularly in interactions with female patients, is vital for maintaining respect and trust. Participants acknowledged that such skills are rarely addressed in formal medical education.

(D6) "Respecting cultural boundaries is crucial. This is something no one teaches us formally."

Theme-2: Communication Skills Training and Professional Development

Doctors expressed that medical training predominantly focuses on diagnosis and treatment, while a formalized pedagogical framework for effective patient-provider communication remains insufficient. Participants strongly advocated for the inclusion of communication curricula from the early years of medical education, emphasizing empathy, clarity, and patient-centered interaction.

(D2) "We learn diagnosis and treatment, but not how to talk to the patient. Communication skills must be included from the start of medical education."

In addition to undergraduate training, participants highlighted the need for continuous professional development through workshops.

(D6) "Workshops on how to handle emotional patients and explain things clearly are needed again and again."

Theme-3: Patient Education and Participatory Engagement

Doctors emphasized that many patients have limited literacy, making conventional verbal explanations insufficient. They recommended using visual aids, diagrams, and simplified language to improve comprehension.

(D6) "Pictures and diagrams often work better than verbal explanations, especially for those who cannot read."

Participants also highlighted the importance of orienting attendants to minimize conflicts and unrealistic expectations. Proper guidance for family members was considered crucial in maintaining a cooperative environment within the ward.

(D9) "If family members are properly oriented, conflicts can be minimized."

Theme-4: Institutional Support for Effective Communication

Doctors reported that overcrowded wards, limited consultation time, and the absence of private spaces negatively affected the quality of interaction with patients. Participants emphasized that meaningful communication requires adequate time and a conducive environment.

(D5) "Patients need time and patience to understand their condition and treatment."

In addition to consultation spaces, participants suggested simple institutional reforms such as clear hospital navigation systems to reduce confusion and anxiety among patients.

(D8) "A clear navigation system would reduce anxiety and improve communication."

Theme-5: Physician Safety and Occupational Well-Being

Doctors strongly emphasized that their personal safety and well-being directly influence the quality of communication with inpatients. Female doctors reported feeling cautious during interactions due to fears of harassment or threats, which limited open and confident communication.

(D4) "We are always cautious about whom we speak to and how, fearing harassment or threats."

Participants stressed the importance of implementing workplace harassment policies, CCTV surveillance, security personnel, and proper reporting systems to foster a safe working environment.

(D9) "If hospitals ensure security and monitoring, female doctors will feel safe and more comfortable while communicating."

In addition to safety concerns, workload and burnout were identified as critical factors. Doctors noted that excessive duty hours and lack of rest reduce their capacity to communicate effectively.

(D7) "Having reasonable duty hours and proper breaks would help prevent burnout and improve patient care."

Theme-6: Interdisciplinary Collaboration and Systemic Reform

Doctors advocated for the inclusion of nurses, psychologists, and social workers to bridge informational and emotional gaps.

(D5) "Patients often need emotional support beyond medical facts."

Strategies Suggested by Inpatients

Theme-1: Availability and Clarity in Clinical Communication

Patients strongly emphasized that doctors should allocate sufficient time for consultations and provide clear, step-by-step explanations.

(P2) "If the doctor spent more time with me, I could understand everything better."

Simplifying complex medical terms into lay language was also highlighted as crucial. Patients valued explanations in words they could easily understand, which allowed them to actively participate in their care.

(P3) "Doctors should use words we can understand and explain things properly."

Attentive listening, eye contact, and respectful dialogue were repeatedly mentioned as behaviors that made patients feel acknowledged. Many patients also expressed a desire for senior doctors to be directly involved in discussions rather than delegating entirely to students.

(P3) "Senior doctors should talk to patients themselves, not just teach students."

Theme-2: Transparency, Accountability, and Patient Feedback

Equity in treatment emerged as a major concern for patients. Many described experiences of favoritism or preferential treatment based on personal connections, which contributed to dissatisfaction and mistrust.

(P4) "All patients should be treated equally, whether they have contacts or not."

Patients also highlighted the need for mechanisms to provide feedback and hold doctors accountable.

(P1) "There should be a way for us to give feedback on how doctors treat us."

Active patient engagement in care decisions was also emphasized. Patients felt that being asked about their concerns and preferences would strengthen trust and reduce feelings of neglect.

(P9) "If doctors involve patients in discussion, trust will improve."

Theme-3: Patient Education and Counseling

Patients proposed multiple strategies to make medical knowledge more accessible. Visual aids, posters, and translated information were suggested as effective tools to bridge literacy gaps.

(P5) "If they put up posters in Urdu explaining diseases, it would help people understand things better."

Language support was emphasized, including the use of interpreters or bilingual staff to communicate effectively with non-native speakers.

(P5) "It would help if the doctor could speak my language or use someone who can translate accurately."

Theme-4: Supportive Care Environment and Family Engagement

Patients emphasized the need for a hospital environment that promotes open and comfortable communication.

(P7) "A quiet place to talk to the doctor would make it easier to share personal details."

Family involvement was also highlighted as an important facilitator of understanding and adherence, especially for elderly or less-educated patients.

(P5) "The doctor should explain things in front of my son. He understands better and helps me follow the treatment."

Theme-5: Professional Conduct and Empathetic Communication

Patients repeatedly suggested that doctors should demonstrate empathy, kindness, and respect in their interactions.

(P2) "Doctors should talk politely; even a soft word gives courage to the patient."

In addition, patients recommended formal training in communication for medical students and junior doctors.

(P10) "Medical students and new doctors should be taught how to talk to patients respectfully and in simple words."

Theme-6: Health System Navigation and Structural Support

Patients also emphasized the importance of guidance mechanisms to facilitate efficient navigation of the hospital system, including staff support and clear signage.

(P3) "There should be someone to guide us about where to go for tests or when the doctor will come. We waste so much time just waiting and wandering."

Several areas of convergence and divergence in proposed strategies to improve doctor-inpatient communication were identified by a comparative analysis of stakeholder viewpoints (Table III). A strong agreement in terms of the need for linguistic adaptation and streamlined communication to address literacy gaps between physicians and inpatients. However, there is a difference in priorities: while inpatients advocate institutional accountability, fair treatment, and active family involvement,

doctors emphasize long-term curriculum integration and structural changes to prevent burnout and ensure safety.

Table III Comparative Analysis of Stakeholders' Proposed Strategies

Domain	Shared Strategies	Doctor-Specific Focus	Inpatient-Specific Focus
Linguistic and Cultural	Use of local dialects; Simplification of medical jargon.	Proficiency in regional languages (Saraiki/Punjabi).	Access to bilingual staff or accurate translation.
Pedagogical	Patient-centered communication.	Longitudinal Curricular Embedding; Formal CPD/Workshops.	Formal training for junior doctors in respectful conduct.
Educational	Use of visual aids; Verifying comprehension (Teach-back).	Orientation of attendants to mitigate conflict.	Repetition of instructions for illiterate populations.
Systemic and Structural	Private consultation spaces; Navigational support.	Occupational safety; Regulated duty hours (Preventing burnout).	Transparency and Accountability; Equity in treatment.

DISCUSSION

The findings demonstrate that improving communication requires a multidimensional approach involving individual competencies, institutional support, and systemic reforms. These findings align with the Deliberative Model, which positions shared understanding and patient-centered interaction as the foundation of effective healthcare.[11] The stakeholders highlighted mutual respect and patient-centered interaction as foundational elements of effective care. Similarly, the importance of trust, concordance, and patient enablement reported in prior studies supports our findings that respectful interaction fosters therapeutic alliance and satisfaction.[6,15]

Language and cultural discordance emerged as a significant theme in our study. Doctors emphasized the need for training in local dialects, while patients stressed the importance of being understood in simple, familiar language. These findings are consistent with systematic evidence demonstrating that physician–patient language discordance is associated with poorer health outcomes and dissatisfaction.[5,16,17]

Intercultural communication barriers compromise care quality and cause inequities.[7] Recent qualitative research further confirms that the absence of a shared language disrupts emotional connection and clarity in clinical encounters.[17] Together, these findings underscore that language competence is not merely a communication skill but a determinant of equitable care.

Health literacy and simplified explanations were central to patient recommendations. Participants reported that medical jargon and rushed consultations hindered comprehension. This aligns with evidence indicating that communication adapted to limited health literacy improves shared decision-making and patient outcomes.[18] Studies have also demonstrated that effective physician communication significantly enhances inpatient satisfaction and perceived quality of care.[19]

Time constraints and heavy workload were identified by doctors as major structural barriers. Similar constraints have been widely documented in hospital settings, where limited consultation time reduces opportunities for active listening and shared decision-making.[20] These results indicate that enhancing communication is an organizational responsibility; success depends on systemic restructuring and workflow improvements rather than the efforts of individual physicians.

Patients strongly emphasized the need for privacy, fairness, and opportunities to ask questions without hesitation. Prior qualitative studies similarly report that patients perceive dignity, confidentiality, and emotional validation as essential components of satisfactory care. [21]

Another important dimension emerging from our findings was the role of training and professional development. Doctors suggested structured communication training and institutional support mechanisms. Evidence supports that language concordance training and communication skill development in medical education can significantly enhance relational competence.[22] Moreover, authentic relational connection has recently been highlighted as a key determinant of sustainable physician–patient relationships.[23]

Limitations

The study could not include other key stakeholders, such as nurses, paramedics, and administrators, who also play crucial roles in communication. Their exclusion was primarily due to feasibility constraints. Furthermore, the study was conducted in a single tertiary care hospital in Bahawalpur, and variations in hospital infrastructure, policies, and patient demographics across regions may result in differing communication strategies.

CONCLUSION

Ultimately, strengthening communication in tertiary care hospitals demands both micro-level behavioral change and macro-level systemic restructuring. Addressing language barriers, promoting health literacy-sensitive practices, and institutionalizing communication training can collectively foster a more supportive and equitable healthcare environment.

Declarations

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