Clinician-Patient Communication Skills and Clinical Education in Nigeria: A Qualitative Study from Benue State

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Abstract:
The practice environment of clinicians is one of communicative relationships. However, clinical education in many parts of the world, including Nigeria neglect adequate prequalification exposure to clinician-patient communication (CPC) skills. In this study researchers explored the exposures to clinician-patient communication (CPC) skills during prequalification education and the nature of professional training opportunities on CPC skills. Designed from the constructivist worldview and descriptive phenomenology approach, researchers conducted in-depth interviews one-on-one with 65 clinicians (physicians, pharmacists, laboratory scientists, nurses and midwives) from 21 of the 23 General Hospitals (GHs) in Benue State. Data analysis followed thematic procedure. Results show a lack of proper prequalification education exposure to CPC skills. Clinicians also lack professional training opportunities for developing CPC skills. Participants reported discordant experiences for and against prequalification educational exposure to CPC skills even within same departments, indicating a lack of policy framework or proper coordination on the subject matter across the clinical institutions and programmes that are producing the clinical workforce for the GHs. Researchers observed a disconnect between clinical education in the region and the sociomedical demands of the practice environment. The practice implication includes a lack of global standard protocols in clinical workforce development such as the Relationship-Centred Care for patient-centred care in Benue State. It also implies a practice environment where communication-related challenges may undermine quality of care. An overhaul is needed, involving a standardised, RCC-based revision of prequalification curricula amongst other things, to enhance core competency skills in line with the needs of the practice environment and global best practices.

Keywords: **Clinician–Patient Communication, Clinical Education, Health Communication, Professional Training, Nigeria.**

1. Introduction

The practice environment of clinicians is significantly socio-behavioural (based on a communicative relationships). While PCC has been globally accepted as the standard protocol for effective clinical interaction (Bolton, 2023; Singhal, et al., 2022; Institute of Medicine, 2001), clinical education in many parts of the world, including Nigeria often neglect adequate integration of communication skills necessary for successful patient interactions (Swasey, 2013; Institute of Medicine, 2003).

Towards addressing this gap, the National Academy of Sciences in her education summit for health professions towards *crossing the quality chasm* developed a vision for the clinical education of the 21st century, focused on patient-centred care and multidisciplinary collaborations for all health professionals (Institute of Medicine, 2003).

Although much has been studied on CPC in Nigeria, its role in the educational foundation of clinicians needs to be investigated, especially in the geographical context of Benue State where the extant knowledge, including Chukwu et al. (2017), Anhange et al. (2022), Saa-Aondo and Sanda (2024) offer no clear answers on the nature of prequalification education exposure of clinicians to the CPC Skills.

Educational foundations are central to professional output of workers both in terms of critical skills (core task performance or creativity) and behavioural or ethical conduct (Aceleanu, 2012; NG & Feldman, 2009). In healthcare delivery, quality of care problems, including issues of patient safety, poor communication approaches, unprofessional conducts among clinicians, and patient health literacy are linked to gaps in educational foundations on CPC skills (WHO, 2016; Institute of Medicine, 2003).

In medical cannons such as the *Harrison's Principles of Internal Medicine*, CPC represents a critical behavioural component of medicine - an enduring value of the medical practice (The Editors, 2022) and the string-bag that holds the medical sciences and social or behavioural sciences together. In fact, the entire *process* of care has been theoretically constructed as a participatory CPC process upon which the quality of care and patient satisfaction largely depend (Donabedian, 2003).

Moreover, among the custodians of clinical education standards, the General Medical Council [GMC](2018) stipulates precisely the communication and relationship abilities of the physician as a hallmark of the *professional skills* required from medical students. These quotations highlight the role of CPC as a *central clinical function* (Simpson et al., 1991) and the metrics for determining the appropriateness or otherwise of the *technical process of care*

(Donabedian, 2003). This is further supported by strong empirical evidences that associate quality of care issues, including complaints and litigations against healthcare workers with CPC failures (Simpson et al., 1991). Therefore, the educational foundations of CPC need to be properly investigated towards improving clinical experiences and the general quality of care.

Research Objectives

I. To examine the nature and adequacy of clinicians' prequalification exposure to CPC skills in General Hospitals in Benue State.
II. To ascertain the professional training opportunities available to clinicians to develop CPC skills.

2. Literature Review

Educational foundation of healthcare workers has been a major concern of researchers for a long time, described as *an expansionist cycle* (Gruppen, 2007) as researchers continue to inquire into wider range of issues affecting medical education.

Biomedical dominance in clinical education

One of the major concerns in the extant knowledge on the nature of clinical education is biomedical dominance - an epistemology in which clinical knowledge is conceived, understood, and measured based on the superiority ideology of medical science and tech. Accordingly, clinical education is largely centred on *hard skills and health technologies for preventing or treating diseases* while knowledge of the human social behaviour including CPC skills are secondary and of little or no concern (Virgolino et al., 2023, p.1)

Early research works are critical of clinical education based on biomedical dominance. For example, the World Conference on Medical Education (WCME, 1988) write that the health needs of man are too enormous for medical science alone to handle; therefore, clinical or medical educators must train healthcare professionals who will address the health needs of the human race holistically rather than those who can only offer curative health services. Also, Swasey (2013) decried the clinical education where pure science courses like physiology, anatomy, biochemistry, microbiology, pathology are *the meat and potatoes* of the curriculum arguing that such a foundation can dehumanise the clinical students making them inefficient in the service to humanity.

There are several other implications of a biomedically centred clinical education. For instance, it does not align the potentials of clinicians with the reality of human health as encompassing a totality of physical, social, and psychological wellbeing (WHO, 1946). Also, such an education orientation is not congruent with the obligations of the hospital as a social institution (WHO, 1957). According to the Institute of Medicine (2001), such medical education lacks the capacity of producing clinicians with the requisite knowledge of the behavioural protocols and relationship skills for the 21st century healthcare. Moreover, a clinical orientation that is basically centred on biomedicine has the tendency of encouraging superiority complex or a caste system in the healthcare sector rather than promote collaboration and team work among healthcare teams (Engel, 1977). In Nigeria, for instance, research studies such as Olajide et al. (2015) have established a linkage between conflict among healthcare workers with professional tussle over hierarchical superiority.

Integration of communication skills in clinical education globally

Recent research works on clinical education are more concerned with innovative perspectives aimed at integrating the behavioural and social sciences in clinical education. In Singapore, for instance, the Accreditation Council for Graduate Medical Education (ACGME) stipulates *personal experience in humanistic skills* as a core competency for the future clinician, whereby a medical doctor, for example, apart from technical, clinical competencies must be able to play the role of a health counsellor and wellness coach to patients through effective patient-centred communication (Khay-Guan, 2019). In Brazil also, the National Curricula for clinical courses have been reviewed reinforcing clinical communication competencies based on the argument that the proper time for health professionals to achieve effective communication skills is during undergraduate studies (Franco et al, 2018).

In the United Kingdom and the United States, *clinical communication education* has emerged over 40 years in the curriculum of medical schools, introduced as the foundation knowledge into medical education during the early years of students' learning (Brown, 2012). In fact, the medical knowledge revolution in the regions has integrated not just clinical communication but the behavioural sciences generally into medical education. In the United States for example, the AAMC has argued that clinicians who are fortified with the knowledge, skills, and attitudes of behavioural and social sciences are more adequately *equipped to provide outstanding patient care, address unanswered questions about human health, and fulfil the mandate of improving the health of the public* (AAMC, 2011, p.5). In the United Kingdom also, the Health and Care Professions Council (HCPC) guidelines on professionalism in healthcare practice underscored the role of diverse aspects of human behaviour, including communication as the key principles of professionalism in healthcare practice. It further argued that serious issues involving *inappropriate* behaviour against patients are often the components of major complaints the healthcare regulators are regularly inundated with (HCPC, 2014).

African and Nigerian context

In Africa, there is substantial dearth of knowledge on the status of CPC in the educational training of healthcare professionals. Although, Matthews and Naidu (2019) investigated the methods of *teaching communication as a core competency in health professions education* at the University of KwaZulu-Natal, in South Africa, which is an indication that the university has incorporated clinical communication in students' training over years for research efforts to start testing the efficacy of the teaching methods.

Generally, however, the extant knowledge indicates that *gaps in health professionals' education* are an exacerbating factor against PCC in Africa as medical education in the continent has largely remained rooted in *outdated colonial-era models*, which do not recognise the necessity of these skills

(Muganzi et al., 2024). Even within South Africa, Matthews and Van Wyk (2018) write that integration of knowledge on its skills is largely an aspiration among medical school educators even though the challenges of the CPC are observed to be common.

In a few places such as the University of the Free State where opportunities for integrating knowledge on CPC skills are found, issues of educator engagement and modelling have been observed (Swinfen, 2020) while in most other parts of Africa, including Nigeria, knowledge is not openly available on the nature of CPC skills in the educational foundations of healthcare professionals. These findings communicate the lack of commitment to integration of CPC skills in clinical education both at regulatory level and also at the level of individual clinical educators in Africa. It means there is no national policy on CPC in clinical education, therefore, adoption or application is discretional at the level of individual institutions and the willingness of individual educators.

In another research perspective, researchers have investigated the efficacy of on-the-job training and postgraduate studies in improving CPC skills. The major argument here is that retaining communication skills can be problematic over time, therefore, the need to further supplement undergraduate education with on-the-job training and also during postgraduate clinical education (Møller et al., 2022). According to Perron et al. (2015) the practice environment is an ideal for teaching and learning CPC skills because such skills tend to decline over time unless frequently recalled and practiced. A study by Møller et al (2022) found out that doctors in Denmark value CPC skills obtained during early year in the mandatory residency postgraduate studies.

Overall, existing literature shows a strong link between CPC skills obtained during prequalification clinical education and effective patient-centred care. Clinical education is considered *the vital basis* for effective CPC skills (Adnan, 2022; Hausberg et al., 2012) and the *only way the future physicians can develop effective communication with their patients (*Ferreira-Padilla et al., 2015, p.311). Efficacy of CPC is strongly associated with undergraduate clinical education (Ditton-Phare et al., 2017); early career postgraduate studies (Møller et al., 2022); and embedded professional training in the clinical workplace (Møller et al., 2022; Brown, 2010).

Theoretical framing: Relationship-Centred Care (RCC)

Existing literature further shows theoretical frameworks supporting the integration of CPC skills in clinical education. One of such theories is the Relationship-Centred Care (RCC), an improvement on PCC model for operationalising the biopsychosocial model in clinical education and professional training (Wyer et al., 2014). RCC teaches clinical educators to view and conceive healthcare largely as *human relationships* – an interpersonal effort at restoration, maximization, and expansion of meaningfulness in all aspects of life not just pathological cure (Soklaridis et al., 2016; Tresolini & the Pew-Fetzer Task Force, 1994).

The RCC is relevant to education exposure because it fosters professional formation of identity, empathy, and communication skills (Kon et al., 2025). Effective application of the model helps clinical students appreciate relationships as a medium of care. It also encourages them to develop the culture of a relationship expert as their professional role in healthcare delivery (Soklaridis et al., 2016) and to develop the core mechanisms of relationship-centred communication: empathy, compassion, and emotional support (England et al., 2020).

According to Hirschmann and Schlair (2020) RCC theory has been used to escalate awareness on the role of social dynamics of health and sickness in clinical education while promoting relationship skills (communications skills) among clinical students. Research has shown that embedding the RCC in undergraduate curriculum can train clinicians who demonstrate equal interest in people *as they are in diseases (*The Royal College of General Practitioners, 2021). In this study, RCC model served as the interpretive framework for understanding clinicians' narratives on CPC in prequalification education and professional training.

3. Methods

The study has been designed from the constructivist worldview given the dearth of knowledge on the phenomenon, which makes it an emerging area of research. Accordingly, descriptive phenomenology approach was adopted to explore clinicians' experiences on exposure to CPC skills during their prequalification education and in the course of service. There was no attempt to test the communication skills of clinicians.

The population of study consisted health workers from the clinical departments of the General Hospitals (GHs): physicians, nursing and midwifery, laboratory scientists, and pharmacists. Sixty-five (65) participants were purposively sampled, one from each of the clinical units across the 23 GHs based on physical presence, seniority (years of experience), and consent. Two GHs (Gbajimba and Okpoga) could not be reached due to herdsmen invasion and kidnapping spree of criminal gangs in the areas, respectively.

Data was generated using in-depth interview procedure to enable researchers extract meaningful knowledge on the phenomenon from the lived experiences of clinicians. Participants were interviewed one-on-one in their offices. One of the participants rescheduled the interview at home while few others on phone due to tight office schedules. The Hospitals Management Board Makurdi granted ethical approval for the study while hospital officials guided the process of data collection to ensure strict adherence to hospital protocols. The Department of Mass Communication, Bayero University also reviewed and approved the study.

Data analysis followed the thematic approach by Braun and Clarke (2006). Data immersion measures include personal conduct of the interviews by the first researcher. This researcher also transcribed the audio records personally and manually. The second researcher confirmed the data by thoroughly reading the manuscript and making comparisons with the audio records where necessary. Transcription followed the *intelligent verbatim* approach in line with the social science interpretivist approach and also for ethical reasons to avoid unintended reputational injury to respondents (McMullin, 2021). Credibility was enhanced through investigator triangulation and repeated engagement with the data.

Coding was deductive using analytic codes drawn from the research objectives while units of analysis were thematised

inductively (drawn from the data) with a focus on rich thematic description of the data, at the semantic level (Table 1). Prevalence was operationalised based on the number of patterned responses across the data set. According to Braun and Clarke (2006) this approach is useful in studies involving under-researched phenomenon as it is the case with the present study.

4. Results and Discussion

The study is aimed at ascertaining clinicians' exposure to CPC skills during their prequalification clinical education and also to find out the professional training opportunities available for clinicians to develop CPC skills in the course of their professional practice. Table 1 below contains the thematic presentation of the findings.

Table 1: A thematic table showing clinicians' exposure to CPC skills during prequalification education and availability of training opportunities on CPC skills during professional practice.

Themes/ Subthemes	Selected meaning units
Clinicians' exposure to CP skills in School	
CPC taught as a core course	It's a course of its own, a core course at 400 level. …a core course, *Introduction to Clerking* at 400 level when we were resuming clinical programme.
CPC a topic in a core course	It was taught under ethics, a core course. It was taught at 500 level under *community health*, a core course
General Communication, not CPC	…communication skills was just a GST (General Studies) course. There was a GS course at year one. Effective communication is there as a topic but not in a clinical setting. Effective communication was a topic under a GST course *English Language*, not related to clinical setting.
No Courses on CPC	…there was no specific course on communication with patients… Family medicine is where those issues of communication with patients are given serious attention.
Professional training opportunities for CP skills development	
Mandatory Continuous Education	…during the mandatory continuous education in workshops, seminars or conferences. Training sessions are organised by the NGOs that are supporting the General Hospitals.
Regulatory Guidelines	…a document *Rights of Patients* issued by the National Association of Nigerian Nurses and Midwives. There is a Standard Operating Procedure issued by the Pharmacists Council of Nigeria…
Informal (on-the-job) Training	We've learnt it in the work, when we see our seniors how they interact with patients… Nurses come together regularly so that experiences are shared and younger nurses learn from the more experienced professional colleagues.
Restricted Professional Training	Hospitals Management Board has restricted opportunities for further studies to part-time arrangement only. Approval for further studies is not forthcoming and when it is granted, there is no sponsorship.

Discordant Voices on Prequalification Exposure to CPC Skills

Findings have shown that educational foundations of clinicians in the GHs in Benue State does not give them adequate exposure to CPC skills. Clinicians reported discordant experiences for and against prequalification educational exposure to CPC skills even within same departments, which points to lack of policy framework or proper coordination on the subject matter across the clinical institutions and programmes that are producing the clinical workforce for the GHs.

Mixed experiences among pharmacy and medical lab personnel

Among pharmacy personnel, for example, some respondents asserted that CPC skills were a core component of their curriculum. Respondent 4 (Assistant Director of Pharmaceutical Services - ADPS) emphasised the depth of CPC in pharmacy training: *it is one of the core aspects of our training enshrined in both the undergraduate and postgraduate curricula at least 8-credit units.* Similarly, several others such as Respondents 12, 29, 41, 45, and 55 claimed exposures to CPC skills, either taught as a core course of its own or a topic under another core course. Conversely, Respondents 25, 28, 51, and 60 reported lack of specific training in CPC except general communication studies as noted by Respondent 25: *It was general communication in English, under GNS 101: Use of English….* Another group of respondents, including 15 and 33 could not remember whether they learnt anything about CPC during undergraduate studies.

Likewise, among laboratory personnel, some respondents claimed educational exposure to CPC skills (Respondents 16, 23, 26, 32, 40, 46, 50, & 54). For instance, Respondent 40 (Principal Medical Lab Scientist) learnt it under ethics, a core course. However, respondent 50 (Senior Medical Lab Scientist) said it was general communication under GST (general studies) course. Another group of medical lab personnel denied prequalification exposure to CPC skills (Respondents 17, 20, & 37). Respondent 5 (an Assistant Chief Medical Lab Scientist) illustrated the depth of this inconsistency, who, despite nearing the completion of a Master's degree, said he had *not come across a course on communication with patients*. Respondent 22 (Principal Medical Laboratory Scientist) further clarified that *effective*

communication was *taught as a topic in a General Studies course but not* in reference to *clinical setting.*

Complex discord among physicians

Among physicians, the discordant responses are more complex with some positions being countered by others. For example, while several physicians said CPC is a key component of the curriculum under medical ethics (or professional ethics), others indicated that *there is nothing much* about communication in the medical ethics. Respondent 63 captures it vividly:

> *Ethics is what guide us, how we do things but the mode of talking, I don't think it was well taken care of…. Although there are ethics, don't do this, don't do that, but that means of communication was not well taken care of* (Senior Medical Officer - SMO).

Another group of physicians (including respondents 8, and 24) expressly denied prequalification exposure to CPC skills.

Consistency in nursing education

In contrast to other clinical groups, nursing professionals demonstrated considerably a consistent educational foundation regarding CPC skills. A vast majority of the responses (including Respondents 2, 9, 27, 39, 47, 65) demonstrated that CPC skills are a core foundation of the nursing prequalification education, often embedded within *Foundation of Nursing* or *Nursing Ethics*. Respondents 65 elaborated that beyond the basic skills, courses on socio*logy of human behaviour* taught her perfect relationship with patients as human beings. Only Respondent 21 (a minority view) denied this exposure, suggesting that nursing curricula are comparatively more standardized in this regard.

Gaps in Policy Guidelines and Knowledge

Further analysis reveals improper coordination of knowledge regarding CPC policies even within the practice environment. Clinicians expressed discordant knowledge about the availability of policy guidelines in their hospitals. While a substantial number of the participants (over 20 respondents across various cadres) said policy documents exists, an equally significant number (approximately 15 respondents) denied the availability of such guidelines. Moreover, a significant number of those who claim the policies exist could not show a copy or mention a title of the documents.

Synthesis and Policy Implication

This finding mirrors the situation in South Africa whereby evidences from available studies such as Matthews and Wyk (2018), Matthews and Naidu (2019), and Swinfen (2020) indicate lack of proper coordination or national policy on CPC in clinical education. It means that integration of CPC skills in clinical or medical education in the continent is discretional at the level of individual institutions and the willingness of individual educators.

The contending patterns in the data implies, apparently, the lack of enforceable canons on prequalification exposure to CPC skills in clinical education. If CPC skills are actually part of the training standard as indicated by some clinicians, it means the monitoring system does not commit enough to ensuring their proper integration, thereby making them discretional at the level of the clinical colleges and or educators.

Furthermore, the findings communicate a possible lack of effective patient centred communication or patient centred care (PCC) in the region since RCC was not operationalised at prequalification education and professional training. With many clinicians lacking exposure to CPC skills and access to policy guidelines, it is difficult they administer coordinated patient centred care. This also means a possible prevalence of communication induced medical errors in the clinical services of the GHs and poor quality of care generally. An overhaul of the staffing system to ensure proper training of clinicians can bridge the gap between inadequate prequalification communication skills and the relationship-based nature of the hospital environment.

Inadequate Opportunities for Professional Training on CPC Skills

The second finding of the study shows that there are inadequate professional training opportunities available for clinicians in the GHs to develop CPC skills.

Reliance on informal and NGO-led training

A number of clinicians (including respondents, 2, 29, 32, 39, 42, and 45) claimed to have accessed opportunities for CPC skills on-the-job through workshops, conferences, and seminars; however, another group suggests that much of the professional training is mentorship and informal arrangements among clinicians in their various units. Respondent 63 captures it clearly: *We've learnt it in the work, when we see our seniors, how they interact with patients...* Respondent 64 further clarified that the training opportunities available are informal, whereby *younger nurses learn from the more experienced professional colleagues*.

Questionable relevance and systemic barriers

The relevance of some of the NGO-led training opportunities to CPC skills is contestable. For instance, Respondent 22 (Principal Medical Lab Scientist, 10 years of experience) claimed that CPC skills were missing from several workshops and conferences attended both at national and international level. Also, respondent 6 (an Assistant Director of Nursing Services, 30 years of experience) identified lack of training opportunities as a systemic problem. Moreover, embargo on further studies and part-time approval for requests on study leave are major challenges confronting professional training in the GHs in Benue State (Saa-Aondo & Sanda, 2024). These barriers hinder clinicians from evolving global standards.

Policy Implications

This finding indicates a gap between the global professional trends in clinical education and the educational foundation of the healthcare workforce in the region. It means that clinical education in the State and care delivery in the GHs is lagging in the adoption of the international best practices in manpower

development, which is critical for the 21st century healthcare needs (Institute of Medicine, 2003). It also means that the clinicians are not properly equipped for the practice environment of care delivery, which has long been established to be sociomedical and requiring effective relationship-centred communication skills (England et al., 2020; WHO, 1957). Implementation of clear operational CPC guidelines in clinical settings while removing barriers to staff development are necessary to enhance CPC efficiency and keep the healthcare workforce relevant to the evolving needs of their service environment.

Conclusion

Clinicians in the GHs in Benue State largely lack the prequalification educational exposure to CPC skills while their practice environment also does not give them enough opportunities to improve their CPC skills. These findings contrast the global knowledge and standards in clinical education such as the Relationship Centred Care (RCC) doctrine. The findings further suggests that the healthcare workforce in the region may not be optimally equipped to meet the sociomedical needs of the service environment.

Recommendations

The state government should ensure comprehensive curricula review across clinical programmes and colleges to include the RCC components for proper operationalisation of the biopsychosocial, patient-centred requirements of the practice environment at clinical education. This may improve the CPC and the general behavioural skills of clinical students, thereby making them more fit for the 21st century practice.

Also, the Hospitals Management Board Makurdi should incorporate advancement of studies as a compulsory component of the staffing system in the GHs. This can bridge the knowledge gap between the behavioural skills of clinicians in line with the demands of their practice environment.

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