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Psychosocial Barriers to Clinical Communication in Public Secondary Healthcare: Qualitative Experiences of Clinicians in General Hospitals, Benue State Nigeria

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Abstract
Psychosocial barriers significantly impact communication in clinical settings, contributing to poor medication adherence and negative patient experiences. While much research has explored patients' perspectives, there is a lack of depth in understanding, particularly given the increasing complexity of these barriers, which is exacerbated by emerging public health issues and requires insight into clinicians' perspectives. This study, employing a constructivist approach and descriptive phenomenology, examines clinicians' experiences with psychosocial barriers in 21 of the 23 general hospitals in Benue State, Nigeria, involving 67 participants. The findings highlight the substantial burden of psychosocial factors such as heavy workloads, dysfunctional facilities, insecurity, and poor staff welfare, which negatively affect communication in the clinical process. Clinicians reported high levels of stress, vulnerability to violence, and inadequate resources, leading to poor professional and patient-centred communication. The study suggests that addressing these psychosocial barriers through better staffing, improved facilities, and a sustainable welfare package is crucial to enhancing clinical communication and the quality of care in the region.

Keywords: Psychosocial, Barriers, Clinical Communication, Public Healthcare, Clinicians' Experiences,

Introduction

Psychosocial barriers have a significant influence on clinical communication. They are associated with poor communication approaches, medical errors, medication non-adherence, and undesirable patient experiences (Shrivastava et al., 2016; Adams, 2019). Unfortunately, clinical practice in many parts of the world, including Nigeria, is plagued by professional stressors, which often become barriers to effective communication (Schaufeli, 2017; Onigbogi & Banerjee, 2019). While much research has explored various perspectives in some parts of the world, gaps exist in extant knowledge on these barriers in Nigeria, including their dynamics and impact on clinical communication. Clinical communication, therefore, is an emerging research area in Sub-Saharan Africa (Larson et al., 2017). Although several studies have been

conducted on some of its components such as the patient-physician relationship (Aluko-Arowolo et al., 2015) and "doctor-patient communication" (Anhange et al., 2022), most of these are quantitative studies focusing on patients' perspectives. Thus, there is a gap in research on clinicians' perspectives, as well as a lack of knowledge on other critical components of the phenomenon, such as patient-pharmacy and patient-medical laboratory communication.

Furthermore, research has indicated that emerging global pandemics, including COVID-19, have significantly impacted professional stress in clinical practice worldwide, thereby further compounding the dynamics of psychosocial barriers in clinical communication. In Africa, the COVID-19 pandemic reportedly generated more "anxiety" among healthcare workers (HCWs) than among the "adult general population" (Mulondo et al., 2024). For example, HCWs in Nigeria were reportedly overwhelmed by "stress, frustration, and anxiety" caused by the unprecedented numbers of victims flooding clinical centres and mortuaries amidst structural failures and resource deficiencies, such as a "lack of Personal Protective Equipment (PPE)" and vaccines (Enem & Samaila, 2021).

Psychosocial stress caused by these emerging trends in Africa is linked to various issues affecting communication in clinical practice, including "migration crises" or the disengagement tendencies among healthcare workers (Oyadiran et al., 2020). These issues contribute to workforce shortages, creating communication barriers as fewer workers struggle to attend to many patients amidst workload pressures. Regrettably, according to the African Union (2020), even with "the risk of placing themselves at the front line of the pandemic" during the height of COVID-19, "migration to high-income countries remained attractive to health workers in the continent." Studies, including those by Onigbogi and Banerjee (2019) and Oyadiran et al. (2020), have shown that more than 44% of registered medical doctors abandoned the service in search of better opportunities, citing the "prevalence of professional psychosocial stress" that has "plagued" the healthcare system in the country.

According to Schaufeli (2017), more research is needed in clinical practice on the emerging trends in professional stress. Onigbogi and Banerjee (2019) also noted that "the prevalence of psychosocial stress is high among healthcare workers in Nigeria," which calls for further research efforts. Moreover, with the impact of emerging pandemics on psychosocial stress, qualitative research has become increasingly imperative to explore the depth of psychosocial barriers in clinical practice and their impact on communication in Nigeria.

Research Objective

The objective of this study is to explore the psychosocial factors that create barriers to clinical communication in General Hospitals in Benue State.

Literature Review

Clinical practice is significantly influenced by socio-political, cultural, and economic factors that affect the communication behaviour of clinicians, whose primary responsibility to patients is communication (Engel, 1977; World Health Organisation (WHO), 2017). Although communication is generally an imperfect activity subject to intervening variables, which, aside from being psychosocial, can also be physical or semantic, these factors are not identical in all communication contexts. In the hospital context, psychosocial factors are known to exert an emotional influence on the participants in the clinical process (the patient and the clinicians), thereby affecting their dispositions towards information sharing, compromise, or even causing aggression and a refusal to cooperate or accept necessary attention (Shrivastava et al., 2016).

Research studies, such as Norouzinia et al. (2016), have indicated significant variations in clinical communication barriers based on context—for example, between patient-related and clinician-related communication. However, both are influenced by psychosocial factors.

Li et al. (2007) observed gender barriers in clinical communication in Europe, where male clinicians tend to be more interactive when dealing with female patients than with male patients. Cultural patterns also constitute barriers, with clinicians reportedly communicating less effectively when interacting with ethnic minority patients compared to ethnic majority patients, while ethnic minority patients, on the other hand, tend to be less expressive and assertive than ethnic majority patients (Paternotte et al., 2015). Furthermore, Leng (2019) found socio-economic barriers, where clinicians reportedly use a linear model with people of low socio-economic status (SES) but a participatory model with high SES groups.

In Asia, Claramita et al. (2011) reported that workload, among other psychosocial factors, affects clinicians, while Claramita et al. (2013) also found that cultural communication patterns negatively affect patient participation in South-East Asia. In Sub-Saharan Africa, knowledge of communication perspectives on psychosocial issues in clinical practice is limited due to inadequate research attention to clinical communication in general.In Nigeria, for example, most studies on clinical practice communication, including Abiola et al. (2014), Ogundoyin (2017), Osiya et al. (2017), Lawal et al. (2018), and Anhange et al. (2022), focus on patient experience perspectives, aiming to establish general communication characteristics, satisfaction, or the impact on treatment outcomes. There are also numerous studies on psychosocial factors in clinical practice, including Angioha et al. (2020) and Nwobodo et al. (2023). However, much of the knowledge they generate relates to the health, welfare, and safety of healthcare workers.

Theoretical Framework

The Structure-Process-Outcome (SPO) Model

This is a theoretical framework developed by Avedis Donabedian in 1966 (Donabedian, 2003), initially for assessing "quality in healthcare delivery" (Ameh et al., 2017). According to the model, effective communication is at the heart of the "process of technical care" (the clinical process), characterised as "an empathetic, participatory patient-practitioner interaction" (Donabedian, 2003, p. 50). In fact, an "appropriate or technically executed" process depends on this effective communication. Accordingly, patient satisfaction and quality improvement are also the outcomes of effective communication (Donabedian, 2003). Again, the model implicitly captures the role of psychosocial barriers as determinants of effectiveness within the system, where patient satisfaction is contingent on the structure and process that are "properly functioning, pleasant, comfortable surroundings, privacy, needed equipment, and qualified personnel" (Donabedian, 2003). The SPO model, therefore, provides a valuable framework for understanding the role of communication in healthcare delivery and the role of psychosocial barriers in the clinical communication process and clinical outcomes.

Job Demand-Resource (JD-R) Model

The JD-R Model, developed by Demerouti et al. (2001), was initially conceived to explain occupational burnout – a consequence of psychosocial barriers (Schaufeli, 2017). However, in this study, the conceptual framework is found useful to shed more light on the nature of psychosocial barriers in the healthcare delivery system, especially how they can emerge in the clinical communication process. According to Demerouti et al. (2001), every work

environment exhibits two characteristics that influence the psychology of workers. These psychosocial characteristics are called Job Demands and Job Resources. On the one hand, Job Demands are the duties, responsibilities, and obligations that come with jobs and roles. On the other hand, Job Resources are the organisational resources needed to perform work, including the reward system (Demerouti et al., 2001).

Job demands are often associated with psychosocial stress, and because of this, job resources are designed to provide a cushioning effect on workers' psychology, thereby promoting job satisfaction and work efficiency (Roskams et al., 2021). Therefore, in a situation where job demands are higher than job resources, or where job resources are not designed with sufficient cushioning effects, the psychosocial stress inherent in job demands tends to dominate the work environment in the form of psychosocial barriers. Demerouti et al. (2001) refer to this as "emotional exhaustion," which explains the overwhelming psychological cost of job demands on workers. The state of emotional exhaustion is always accompanied by "disengagement," meaning that once this state is reached, the tendency to leave the job becomes the major preoccupation of the worker.

Application of Theoretical Framework

The clinical process and healthcare delivery system, in general, is complex, and thus the nature of the communication process within it is also complex. Therefore, the templates of the models have been used to provide a clear picture of the clinical communication phenomenon, including the nature of psychosocial noise that accompanies it. By reading the theoretical framework, the reader gains an understanding of the meaning of these key variables in the context of this topic. Secondly, the constructs of the two models have been used in framing the interpretation of data and findings. This was important to remove any potential biases arising from the researchers' knowledge and ethnographic experiences of the healthcare system. Having clarified the key concepts of the study, the researchers leveraged the constructs of the models to identify the exact variables relevant to the research objective from the volumes of data generated for the study. Furthermore, the frameworks were used to identify patterns in the data regarding the behaviour and relationship between psychosocial barriers and clinical communication. The researchers found this useful in organising the interpretation of findings and explaining these relationships as contained in the discussion section.

Methodology

The study adopts a constructivist approach, with in-depth interviews as the method for generating data. The population of the study comprised 67 clinicians from 21 of the 23 general hospitals in Benue State. Four clinical units are consistent across the general hospitals: consulting, nursing, laboratory, and pharmacy. Therefore, for each of the hospitals visited, one person was interviewed from each of these units. Sampling was purposive—based on seniority (years of experience) and accidental—based on availability (physical presence and consent). Clinicians with less than two years of work experience were purposively sampled out of the study. Also, two general hospitals, Okpoga and Gbajimba, were purposively excluded due to kidnappers' activities and herdsmen attacks, respectively.

The in-depth interviews were conducted face-to-face with clinicians in their offices. However, telephone interviews were used for a few respondents who could not spare time due to tight office schedules. Ethical approval for the study was obtained in writing from the Hospitals Management Board (HMB), Makurdi. At the hospital level, medical officers in charge granted

unwritten approvals based on evidence of the letter from HMB. All hospital protocols were duly respected. To credibility of data and the findings, the study was designed under the close monitoring, scrutiny, counsel, and ratification of a professor of health communication. Data and findings were further subjected to scrutiny by two research panels comprising PhD holders and professors in the Faculty of Communication at Bayero University, Kano, Nigeria, who approved the validity and reliability of the data and findings.

Credibility has been strengthened by multiple quotations from data notes, representing direct statements from respondents. The researchers also included vivid descriptions of respondents, their ranks, and years of experience. Moreover, the robust sample size of 67 interviews is a major factor in ensuring the credibility of the data and its transferability, as views from all the general hospitals in the state were adequately represented.

Table 1. Demographics of Respondents

Professional Categories of Respondents	No. of Respondents	Ranks of Respondents	Years of Service (No)
Nursing	19	CNO, ADNS, NO, SNO	6-10yrs (3) 16-20yrs (2) 26yrs above (14)
Consulting	18	SMO, PMO, MO.	2-5yrs (14) 6-10yrs (3) 11-15yrs (1)
Medical Laboratory	15	ACMLS, ADLS, PMLS, SMLS, CMLT, SMLT MLT, LM.	6-10yrs (7) 11-15yrs (2) 16-20yrs (2) 21-25yrs (1) 26yrs above (2) Not indicated (1)
Pharmacy	15	ADPS, CP, PP HPT, PT, PA, SPT.	2-5yrs (4) 6-10yrs (3) 11-15yrs (4) 16-20yrs (1) 21-25yrs (1) 26yrs above (2)

Source: Researcher's Field Work, 2021

Findings

Descriptive phenomenology was used in analysing data for the study based on "Giorgi's four-phase method" as described by (Ojala, et al., 2014). According to Isabirye and Makoe (2018), this method has potentials to produce highly related results of participant experiences. In the first step: Reading the transcription several times, researchers engaged with the data notes to establish a general idea of each participant's experience. The use of personal interview strategy established this needed familiarity with data and was enhanced through the manual process of transcribing each interview record. The corresponding author personally transcribed and also typed the scripts while the second author reviewed the transcripts and listened to the original records where necessary.

In the second step: delineating meaning units, the researchers marked out each participant's statements that indicate an experience of psychosocial barriers. These were extracted and tabulated. Next, researchers restructured the meaning units into themes in line with the

requirement of step three: collecting meaning units together and forming a meaning structure (see Table 2). Lastly, a comprehensive synthesis of participants' expressed opinions was done under each of the themes.

Table 2: Thematic Map on Psychosocial Barriers to Clinical Communication in General Hospitals in Benue State.

Themes	Selected Meaning Units
Poor staff welfare	"…Since 2012 they have stopped our annual leave grants." "…as I am talking to you now, two months' salaries are yet to be paid." "…You can imagine if a medical doctor is facing challenges of poor welfare, what will an attendant be saying?"
Workload pressure	"As I am talking to you, am the only government staff here now…" "…One nurse is at work covering more than one ward and the same nurse comes back to cover the night duty." "…you can see one person doing two or three things at the same time."
Dysfunctional Facilities	"…Nothing seems to be working; mattresses are bad, no reagents in the laboratory, no light, for the past three months I think we have seen light here twice." "…See where I am staying. Look at it yourself, look at the ceiling leaking since water fell three days ago; see water dropping everywhere." "Several procedures that are supposed to be run here we don't do them because the equipment and manpower are not there."
Insecurity	"Criminals have an erroneous perception that doctors have a lot of money; so, we have become their target." "…You hear cases of kidnapping almost every day. We are working under a tense environment." "…Violence is a common thing around the community; most relatives of patients become violent at a slight misunderstanding. A doctor was even fought on duty."
Rural Poverty	…due to high rate of poverty, many patients find it challenging to pay their bills. "So many patients because of poverty…want free treatment." Payment of hospital bills has always been a source of misunderstanding between patients and clinicians. …whatever counsel or advice the clinician give, they won't shift grounds because there is no way they can afford any of the options…
Patients' Negative Perceptions	Some patients are difficult to manage because they come with mind sets entirely inimical against clinicians. …some patients don't like consulting certain doctors… Patients have various perceptions of doctors that make them develop preferences among doctors. …they are not always willing to talk once they come and it is not their person on sit.
Social Addiction	Some patients find it difficult to adhere to medical decisions because they are addicted to certain lifestyles. … it was impossible for him to abstain from sexual intercourse for just one day.

Syntheses

Poor Welfare

Poor welfare reflects in all participants' responses. It manifests in the forms of irregular salary payment, poor accommodation facilities, poor salary structure, embargo on study leave, no annual leave grants, and exemption of clinicians from fringe benefits for state government workers. According to Respondent 1 for example, "welfare is a serious challenge affecting every hospital staff. You can imagine if a medical doctor is facing challenges of poor welfare, what will an attendant be saying? As am talking to you, two months' salaries are yet to be paid" (SMO, 6YE). "Since morning! Anywhere you go record this thing o. I ate *Indomie* in my house since morning up till now (1:38pm)! No salary. Salaries are not being paid at the right time" (Respondent 50, SMLS, 15YE). Respondent 59 also said "since 2012 they have stopped our

annual leave grants. The minimum wage, they don't give us, they say they will give grade levels 1-6. July salary has not been paid, and we are in August today, August 25th" (CNO, 34YE). The government has placed embargo on further studies citing a shortage of staff (Respondent 23, SMLT, 15YE).

Moreover, respondent 34 said nurses' salaries are reducing with experience instead of increasing. "…When I was a PNO my salary was about three hundred thousand naira plus, now it is two hundred, now that I am Chief…" (CNO, 32YE), etc. Poor welfare leads to withholding of information among clinicians. "…when you are hungry or tired, it reflects in how much information you are willing to pass to patients" (Respondent 29, CP, 10YE). It affects the comprehensiveness of care given to patients because "health workers too are humans; they have families. They have bills to pay and so many challenges" (Respondent 64, SMO, 3YE). Poor welfare leads to unprofessional attitudes among clinicians. "Someone who is not well cared for can easily lose control of their temper no matter how hard they may try to hold themselves. This has often resulted in to transfer of aggression and unsupportive attitudes of some members of staff" (Respondent 1). "There is what is called transfer of aggression…because we are frustrated, so, when they ask us anything, then you flare up, sometimes you do it before you realise that you have done a wrong thing" (Respondent 10, CNO, 33+YE).

Respondent 8, PMO, 9YE also observed some "unprofessional attitudes such as transfer of aggression, refusing to give patients attention or avoiding them …though associated with young practitioners." These are frustrating experiences that keep tempering with workers emotions, especially in the face of impatient, troublesome patients. So, it has resulted in transfer of aggression sometimes (Respondent 23, SMLT, 15YE).

Poor welfare affects clinician-clinician communication. For example, it weakens the monitoring system as management finds it difficult to enforce professional guidelines. "It's a huge challenge for management because as the Medical Officer in-charge, from your conscience you find it difficult to exercise control over your staff members" (Respondent 1).
Poor welfare promotes disengagement tendencies among clinicians. The interest of many clinicians in their jobs has been severed by the psychosocial stress of poor welfare. They go to work just to keep themselves busy while looking for better opportunities. "…sometimes we just keep pushing and hoping we get a better job somewhere and leave this place" (Respondent 58, SMO, 3YE). Poor welfare also causes depression among clinicians. "Sometimes I come here depressed, sick myself and trying to see another sick person because of how many months of non-payment of salaries" (Respondent 35, MO, 4YE). "…when you don't eat well and you are working, you have children, you also fall sick… Definitely, it affects our mood even though we try…but psychologically…sometimes mental fatigue and all of that…" (Respondent 31, PMD, 13YE). Those things are frustrating… You are hungry, and you are attending to 10, 15 patients, what if you collapse?" (Respondent 66, SNO, 10YE). Poor welfare promotes medical errors. There are several instances where patients allegedly complain about the manner of approach of staff members. According to respondent 53, "it also results in medical errors because they affect your concentration, which ultimately results in errors that shouldn't be there… Most a time, your mind is not there because of hunger… (SMO, 2YE).

Workload Pressure

Workload pressure also reflects in the responses of all participants. For example, according to respondent 57, "…The doctors are only three and one is always absorbed in administrative

work but there are several clinics and emergency cases are also there… (SMO, 3YE). "…Sometimes a single nurse is on duty…The nurse on duty will be required to cover the entire hospital alone" (Respondent 10, CNO, 33+YE). According to respondent 56, "the time the nurses are supposed to close, they don't close. The time they are supposed to have their off days, they don't. Like me now, I resumed today's duty since 7am, maybe before I go to bed it will be around 1am" (CNO, 32YE). Respondent 2 said she was working in two offices at the same time: "you see my office is down there, but because there is nobody in this office, I have to cover it. So, I am working in two offices at the same time today… Right now, it's only one staff on duty from 7am to 6pm, then another from 6pm to 7am (CNO, 33YE).

Workload pressure hinders patient-centred communication. "Often, there are certain things that you need to discuss with your patient but you have plenty on your hands and everybody wants your attention" (Respondent 66, SNO, 10YE). Most times, the holistic approach is hampered. "Holistic pharmaceutical care is almost neglected if it is a follow-up patient. Emphasis is reduced to drug dosage; counselling becomes necessary only for highly sensitive cases (Respondent 45, CP, 11YE). Respondent 12 also said "we don't have enough time to talk to everybody as we should. Old clients who we are sure are stable and doing well, most times we are not detailed in the entire procedure again because of workload pressure" (PP, 8YE).

Workload affects the quality of time given to patients. "Look at the time [12:12 noon], I have not even greet the patient in this ward [pointing at the next door] because of workload…" (Respondent 2). "We don't give them quality time." Respondent 15 further said most times the discussion is focused on drug dosage only (ADPS, 21YE). "When you have many patients waiting to see the doctor, you have to adjust so that you can attend to everyone on time" (Respondent 21, SMO, 2YE). Workload pressure leads to negligence of patients' concerns. There are common cases of Patients' complaints of nurses' neglect because of shortage of nurses (Respondent 49, CNO, 30YE). There are several instances of patients complaining about the attitudes of nurses, and some are not satisfied with the attention given to them (Respondent 52, CNO, 34YE). According to respondent 15, "sometimes you are bored down and you want to close for the day but you see some patients coming late. As human beings sometimes you refer them to the following day. This happens often, but it's not supposed to be so" (ADPS, 9YE).

Workload pressure prevents comprehensive care: "One nurse is running a shift alone for a whole day. The same nurse is taking care of all the wards, she is divided among several patients; so, comprehensive care is not possible" (Respondent 52). "The hospital is category C, expected to have at least six medical doctors but currently we are only two. This means much workload for us, which also affects the time and depth of interaction…sometimes you decide to tailor the communication basically to patient symptoms." (Respondent 1, SMO, 6YE). Workload pressure leads to communication misconducts. According to Respondent 5, there are instances of transfer of aggression arising from workload and pressure on time (ACMLS, 16YE). Moreover, workload pressure often makes young nurses tend to misbehave or issue unprofessional comments to patients (Respondent 6, ADNS, 30YE). Again, cases of transfer of aggression have been observed as a result of time pressure (Respondent 30, DDNS, 30YE). Workload leads to patients' negative perceptions of clinicians. "Sometimes patients may feel the nurses don't care enough, whereas it is due to the fact that few nurses are divided amongst many patients" (Respondent 14, CNO, 26YE).

Dysfunctional Facilities

This theme also reflects across participants. For example, Respondent 1 pointing at a jalopy vehicle through a window said: "That's the only ambulance we have, yet it is not functional" According to respondent 48, "there are no equipment to work with, anything you can think of; it's almost everything. Nothing seems to be working! Mattresses are bad, no reagents in the laboratory, no light; for the past three months, I think we have seen light here twice (MO in-charge). Also, with a wrinkled face, Respondent 35 said: "I have just one ward here. I put surgical patients there, medical patients there, a coughing patient who is supposed to be given a special ward…I also put there because I don't have a choice... (MO in charge).

"Sometimes it takes months to have some reagents provided." For example, "Gimser Stain" used for comprehensive malaria testing is always out of stock… (Respondent 26, HOD Lab). "I wish you had taken a look at our theatre. We don't have anything… the operating table is bad, no operating light, even the suction machine we don't have a functional one…no ambulance" (Respondent 58, SMO, 3YE). Dysfunctional equipment promotes psychosocial stress. "Oftentimes you watch yourself helplessly a patient give up because our referral services are not optimised. This has been my number one frustration" (Respondent 1). "It is frustrating when you write medical reports knowing fully well that it is not the true reflection of the patient status" (Respondent 26, HOD Lab). "It's always frustrating when you don't get what you want to give to your patient, especially as this is a rural area" (Respondent 24, SMO, 2YE). "It is frustrating when you are given training but when you come to practice you find it difficult because of lack of facilities…" (Respondent 34).

Lack of facilities causes misunderstanding, patients' anger and aggression against clinicians. Often, patients become aggressive, they shout at lab personnel especially during emergencies when there is an urgent need and the personnel can't attend to patients because those things are not there (Respondent 40, PMLS). According to respondent 26, much of what causes anger in the Lab is the non-availability of reagents to perform tests. Lack of facilities hinder clinical interactions. "There are no call rooms; sometimes it is difficult to have the attention of clinicians during emergencies because they have to close and go to their homes… (Respondent 24, SMO, 2YE). "Some people are staying as far as Makurdi and there is only one road linking this place and Makurdi. So, anytime the killer herdsmen block the road, they either don't come to work or they are forced to stay in here" (Respondent 34).

Insecurity

Insecurity manifests in a form of a violent culture in some host communities of the study area. "Violence is a common thing around the community. Most relatives of patients become violent at a slight misunderstanding. A doctor was even fought on duty. The hospital was almost closed down" but for the intervention of community chiefs who have been issuing strong warnings against violence on health workers (Respondent 49, CNO, 30YE). "Some of them will say they don't have money, and they want me to run the test free for them…some of them even want to fight with me, to force me to do the test free for them." (Respondent 50, SMLS, 15YE). Insecurity also manifests in the form of activities of criminals. According to respondent 13, "criminals have an erroneous perception that doctors have a lot of money; so, we have become their target. Once they identify you as a doctor, you become a target" (SMO, 5YE). Respondent 13 also said "the insecurity here is very bad. You hear cases of kidnapping almost every day. We are working under a tense environment" (MO, 6YE). "Insecurity has crippled everyone. Doctors and nurses in General Hospitals are being hunted, kidnapped for ransom. The bandits think we have money, and we are their targets" (Respondent 57, SMO 3YE).

Absence of perimeter fence makes clinicians feel unsafe. “The hospital has no perimeter fence…It adds to threats of insecurity” (Respondent 24, SMO, 2YE). “You can look around; this is the hospital premises, no perimeter fence, your security is not even guaranteed” (Respondent 34, CNO, 32YE). Insecurity also manifests in a lack of job security for physicians on bond agreements with the State Government. The government established a bond agreement with medical students where the government undertook to subsidise medical education while students undertook to serve the state for an agreed period. Unfortunately, “when the period of compulsory service is over, those who want to continue their services with the State find it challenging to be absorbed by the Board…” (Respondent 53).

Insecurity promotes disengagement tendencies among clinicians. “Sometimes you wake up, and you don’t feel like going there because what are you doing it for? You understand? You keep on saying you are saving lives but you need to save your own life first (Respondent 13). “During discussions among ourselves, those who never contemplated leaving the shores of the country for any reason are now changing their initial decisions” (Respondent 57). “So, everybody is just leaving the State services. In the near future, we will not have doctors in the State service” (respondent 53).

Rural Poverty

Almost all the General Hospitals are in poor rural communities. Many patients because of poverty find it difficult to settle their bills. So, payment of hospital bills has always been a source of misunderstanding between patients and clinicians (Respondent 27, CNO, 30YE). “General Hospitals offer standard healthcare that has not been subsidised and most of the patients can’t afford it because of poverty” (Respondent 57).

Poor rural economy makes it difficult for clinicians to reach agreement with patients on treatment options. “Some patients make treatment suggestions based on how much they have in their pockets, and sometimes, whatever counsel or advice you give, they won’t shift grounds because there is no way they can afford any of the options for the wholesome treatment” (Respondent 29, CP, 10YE).

Poverty makes patients abandon treatment. Sometimes, the treatment will not be completed but they will sign and go (Respondent 27, CNO, 30YE). Poverty causes misunderstanding between patients and clinicians. Many who find it difficult to afford hospital bills tend to push their frustrations at nurses” (Respondent 67, SNO, 10YE). “…It often results to misunderstanding when they want free drugs and the personnel can’t help them” (Respondent 51). "There is much poverty in the community…. This often cause misunderstanding between patients and nurses because once the patient doesn’t pay as instructed by the doctor, the nurse can’t care enough because the pharmacy won’t release the medicines” (Respondent 47).

Patients’ Perceptions

“Some patients will tell you I don’t want that mommy to take my sample. I want this aunty to take my sample” (Respondent 32, CMLT, 16YE). According to Respondent 45 (CP, 11YE) regular patients always exhibit negative perceptions against some personnel. “Some patients will come here and say I want to see the huge man.” Some nurses are seen as unsympathetic and uncooperative. “Sometimes they will tell me that “that nurse should not touch me” (Respondent 9, CNO, 32YE).

Patients' Perceptions affect communication negatively. Negative perceptions lead to avoidance while positive perceptions lead to attachment. Patients' attachment adds to the workload of some clinicians resulting to lack of time for proper attention and holistic communication. Avoidance has often resulted to patient withdrawal when the clinician being avoided is the only option available. "Some patients have developed attachment to particular clinicians, so they are not always willing to talk once they come and it is not their person on sit" (Respondent 8, PMO, 9YE). Respondent 12, PP, 8YE also shared instances where patients insisted on seeing particular doctors and once it is not the doctor they want to see, they go back. "There are also instances where patients on admission protested that some nurses shouldn't attend to them" (Respondent 12).

Communication approach and perceived expertise of clinicians determines patients' perceptions. "Some patients prefer to see you maybe because of the way you welcome them at first instance…Some of them insist on seeing you because maybe you treated their brother or sister who got well, so they feel this one is the best doctor" (Respondent 7, SMO, 3YE). "Sometimes a patient is tired of complaining one thing to a particular person, they become nonchalant towards that person" (Respondent 18, SMO, 3YE). According to Respondent 22 (PMLS, 10YE) some patients prefer the services of certain lab personnel over others sometimes because of the manner of approach, bias in attending to patients and segregations.

Social Addiction

There are evidences of addiction to unhealthy lifestyles that hinder effective clinical interactions. For example, Respondent 20, LT, 9YE, gave example of a patient who could not produce viable semen for analysis because it was impossible for him to abstain from sexual intercourse for just one day. Social addictions prevent adherence to medication.

Discussion

This study was designed with the objective to explore the social factors that can manipulate the psychological disposition of clinicians thereby imposing barriers to clinical communication in General Hospitals in Benue State. Findings have shown that there are several social issues with negative effect on emotional stability of both clinicians and patients resulting to indisposition to meaning sharing, reaching agreement or aggression and cynicism. These issues include poor staff welfare, workload pressure, dysfunctional facilities, insecurity, rural poverty, patients' perceptions and social addiction. An emerging definition of these psychosocial factors from the data notes states that "these are frustrating experiences that keep tempering with workers emotions, especially in the face of impatient, troublesome patients" (Respondent 23, SMLT, 15YE). The impact of these issues on clinical communication is many folds. For example, they have elicited mass disengagement of experienced clinical workforce known for driving effective clinical interactions. Several medical doctors have reportedly resigned while many others "just keep pushing and hoping will get a better job somewhere and leave" (Respondent 58). So, "everybody is just leaving the State service" (Respondent 53).

To further support this fact is the years of work experience of most of the clinicians who are at the basic level of their careers (See Table 1). Most of the medical officers are General Practitioners within five years of work experience. Also, most of the Laboratory Scientists. Also, most of the Laboratory Scientists and Pharmacy personnel are holders of elementary certificates, mostly Technicians, who were met on ground as the most senior personnel to participate in the study. Regrettably, inadequate experience in clinical practice has been associated with communication problems leading to medication errors (Avalere Health, 2015).

Similarly, findings show a prevalence of depersonalisation behaviours allegedly associated with the newbie clinicians (Respondents 6 & 8). These are largely communication misdemeanours such as implicit bias, transfer of aggression, shouting at patients and denying them the cooperation they needed.

This finding explicitly resonates the position of the theoretical framework of this study. In the JD-R model, the psychosocial barriers, represented by excessive job demands, often result to "emotional exhaustion" given rise to "disengagement" (Demerouti, et al., 2001). In Nigeria, just as in other parts of Africa, disengagement as a result of psychosocial barriers, is common in the healthcare sector (Onigbogi & Banerjee, 2019; Oyadiran, et al., 2020). Depersonalisation also is a common misconduct among health workers (Ogunsuji, et al., 2019; Vance, et al, 2021), captured within the theoretical framework of the JD-R model as "cynical, detached behaviours to clients" (Demerouti, et al, 2001). Again, in the SPO template, "qualified healthcare personnel" is a basic structural need for the clinical process to function "appropriately" (Donabedian, 2003). Therefore, the prevalence of inexperienced clinicians occasioned by the burden of psychosocial issues is a justification that the issues have constituted barriers to effective clinical interactions in the area under investigation.

Another novel finding of this study is that the psychosocial barriers hamper holistic approach to clinical communication. Also called the biopsychosocial communication approach (or model), the holistic approach represents the globally accepted model for patient-centred clinical communication (Schiavo, 2007; Parse, 2019; Singhal, et al., 2022). Human health is said to be "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organisation, 1946). Also, patients' health-seeking behaviours, including acceptance of medical advice and adherence to medication are influenced by psychosocial factors as it is evident in the findings of this study. Therefore, the biopsychosocial approach enables clinicians to identify those psychosocial issues and offer appropriate counsel and health education so that patients can manage their challenges effectively after clinic.

Regrettably, the data notes indicate that clinicians in General Hospitals in Benue State have often neglected the holistic, patient-centred approach due to the influence of psychosocial barriers. For example, according to Respondent 45 "holistic pharmaceutical care is almost neglected if it is a follow-up patient. Most times emphasis is reduced to drug dosage; counselling becomes necessary only for highly sensitive cases." Respondent 57 also stated that the biopsychosocial approach "is difficult and very challenging given the resource-deficient environment" in which they have found themselves. "One nurse is running a shift alone for a whole day. The same nurse is taking care of all the wards, she is divided among several patients; so, comprehensive care is not possible" (Respondent 52). "…It affects the time and depth of interaction…sometimes you decide to tailor the communication basically to patient symptoms" (Respondent 1).

This finding also resonates the position of the theoretical framework as contained in the SPO model. From the tenets of this model, patient-centred communication, represented as "an empathetic, participatory patient-practitioner interaction" (Donabedian, 2003) is central to the clinical communication process. In fact, it is the metric or index for measuring the appropriateness or otherwise of the clinical process. Therefore, juxtaposing the findings with the SPO model, the clinical communication process, and by practice implication, the healthcare delivery in the General Hospitals in Benue State is not "appropriate," not "expertly executed"

(Donabedian, 2003). Correspondingly, the data indicates prevalence of poor communication patterns, which manifests in several ways, including lack of value for communication among clinicians, patients telling pharmacists what they should have told doctors, patients' attachment and avoidance behaviours, which are blamed largely on poor communication approach.

Moreover, the study found a negative impact of psychosocial barriers on clinician-to-clinician communication. It is evident in the data that the monitoring system has been weakened such that medical directors face the challenge of ensuring compliance to appropriate professional guidelines. In the words of Respondent 1, "it's a huge challenge for management because as the Medical Officer in-charge, from your conscience you find it difficult to exercise control over your staff members."

Among the implications of these findings, they explain the lack of commitment of the Benue State government over a long time to public secondary healthcare as it is evident in the numerous structural issues that have become barriers to proper execution of the clinical process. By way of practice implication, it means the quality of care in public secondary healthcare services of Benue State Government is poor, albeit the findings offer valuable insights for quality improvement. Again, the findings offer a projection into the future of public secondary healthcare delivery in Benue State. The massive structural decay, the emotional exhaustion, and the high disengagement tendencies among skilled clinicians, these do not offer hope for sustainability of the subsector as they portend imminent total collapse of the system. Prioritising the subsector in the State's economic plan is very important to salvage the General Hospitals from their moribund state.

Conclusion

Several social issues, including workload pressure, poor staff welfare, rural poverty, dysfunctional facilities insecurity, patients' perceptions, social addiction and stereotypes or implicit bias have constituted the structural inefficiencies in public secondary healthcare delivery in Benue State, which are manipulating the emotional stability of clinicians and consequently imposing barriers to clinical communication effectiveness. From the theoretical lenses of the JD-R model, some of these issues like workload pressure, insecurity, rural poverty and social addiction represent the excessive job demands in the work environment while dysfunctional facilities represent the resource-deficiencies. The political will and commitment of the hospitals management is crucial towards improving these structural issues. Also, in the light of the SPO model, negative patients' perceptions and stereotypes or implicit biases are manifestations of issues with staffing. It means that the "needed qualified healthcare personnel" that can "expertly execute appropriate process of technical care" is lacking in the General hospitals (Donabedian, 2003). Improving the emotional stability of the available skilled personnel through sustainable staff welfare schemes such as providing opportunities for advancement of knowledge and skills will curtail the disengagement tendences and improve the process of care.

Recommendations

The Benue State Government should show more commitment towards improving the structures for public secondary healthcare delivery by investing more in proper staffing, facilities and equipment, and by creating sustainable staff welfare packages that will improve emotional stability of workers. This will bridge the existing wide gap between job demands and job resources, encourage and sustain the interest of clinicians in the State service, curtail disengagement tendencies, and improve clinical interactions and the general process of care.

Moreover, the Health Management Board Makurdi should collaborate with security agencies on innovative strategies to boost security of the personnel and equipment in the General Hospitals. Furthermore, the Board should create training opportunities for clinicians who are at the basic level of their careers to advance in knowledge and skills. This will enhance expertise in clinical interactions and the general quality of care.

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