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Communication Barriers between Medical practitioners and Patients from Medical Practitioners' Perspective

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ABSTRACT

Communication between medical practitioners and patients are in many cases ineffective, with consequences ranging from inadequate health facilities to malpractice cases. The problems may also be related to the intercultural differences in interpreting medical practitioner-patient relations based on different expectations and interpretations, attributed to the verbal and nonverbal symbols exchanged between the two parties. Based on a phenomenological perspective, this study aimed to explore those communication barriers as perceived by medical practitioners. This study employed a qualitative research method, interviewing 28 medical practitioners. The results of the study showed that there were four main barriers encountered by medical practitioners when dealing with patients in their therapeutic communication. These barriers were related to: (1) cultural differences; (2) educational differences; (2) time barrier; and (4) psychological differences.

Keywords: Communication barriers, medical practitioners, patients, therapeutic communication

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INTRODUCTION

With a population of 267 million people (as of 2019), Indonesia has its own unique issues in the field of heathcare and disease. These problems include, among others, the lack of health facilities; the lack of medical practitioners throughout the country, especially in villages that are out of reach; inadequate government management of public health; and problems related to communication between medical practitioners and patients.

Long ago, the chair of YLKI (*YayasanLembagaKonsumen Indonesia,* or the Foundation of Indonesian Consumers) Indah Sukmaningsih, admitted that the main problem facing healthcare in Indonesia was the ineffective communication process between medical practitioners and patients (Rinawati, 2008). The argument is still valid, and even more so today. It is estimated that almost one million Indonesians travel overseas, especially to Singapore and Malaysia, to receive medical treatment (Ormond, 2015). One of the main causes of this phenomenon is the relative inability of medical practitioners and hospitals in Indonesia to communicate effectively with patients, resulting in patient dissatisfaction with their treatment.

Medical practitioners and patients may have differences not only in their understanding of a desease or illness, its causes, and the best course of treatment, but also in the way they communicate verbally and nonverbally. If either party does not adapt well in a communication encounter, a more serious misunderstanding will likely occur. Medical practitioners and patients are essentially two disctint groups; each of them has unique way of communicating. Cultural differences between them may make the problem even more complex, since every culture is comprised of specific cultural beliefs, and values connected to language, religion, and worldview.

Medical practitioners and patients not only need to think about how to seek solutions in treating a desease or illness; they also need to consider the way they interact with each other. Effective communication is the core of healthcare and health promotion (Berry, 2007; Gully, 2009; Rosenbaum & Silverman, 2014; Villagran & Weathers, 2015). Effective interpersonal communication has become imperative, as health professionals have to negotiate work practices in order to ensure job satisfaction, and to creatively deal with workplace changes (Glass, 2010). Myerscough and Ford (in Eckler et al., 2009) contended that "Communication is the most common cause for complaints from patients, and an apparent weak point among doctors".

Health communication has now become a concern for researchers as a result of many cases of medical malpractice. Statistics have shown that 98,000 patients die all over the world every year due to medical malpractice (Hannawa, 2009). This tragedy has been called a 'hidden epidemic' because the associated medical practitioners, patients, and hospital staff chose not to talk about it (Carmack, 2010). In Indonesia alone, the number of such cases is significant. There were 40 reported cases of medical

malpractice in Indonesia in the year of 2009, and another 20 cases from January to July 2010 (surabaya.detik.com, August 1, 2010). The deaths of the celebrity Sukma Ayu (2004); a woman named Siska Makatey, during childbirth (2013); and the death of a baby named Debora, who was rejected by a hospital (2017), are among numerous cases highlighting medical practitioners' negligence of their duty. A large number of medical disputes between medical practitioners and hospitals on one side, and patients on the other side, have been brought to court. The most controversial and notable case, known as the Prita case, occured during the period of 2009-2012.

As Mulyana and Verity (2016) illustrated, Prita Mulyasari, a resident in Tangerang, Indonesia, was involved in a legal dispute with Omni International Hospital. The legal battle was initiated by the Hospital in response to an e-mail Prita sent to family, friends and colleagues regarding her healthcare experience at the hospital: an e-mail that subsequently went viral. Remanded in custody for three weeks in 2009, Prita was charged under relatively new Indonesian civil legislation, which was introduced in 2008 with the purpose of regulating digital communication. The Hospital argued that Prita's e-mail was defamatory, and damaged the reputation of the attending medical practitioners, and the Hospital. In the end, assisted by mass social support, as well as by the involvement of some notable political figures, Prita won the legal battle against the hospital.

In a country like Indonesia that consists of hundreds of ethnic groups, each with their own culture, and where paternalistic values are still dominant, the role of therapeutic communication may be greater than that in more liberal Western countries. In Indonesia, many medical practitioners still consider patients to be passive objects of medical practice, failing to acknowledge the fact that patients themselves have a right to know the details regarding their condition and treatment. Moreover, many patients are reluctant to ask questions about their health to their medical practitioners, because they consider themselves to be of a lower social status.

In the era of globalization it is essential that medical practitioners possess intercultural competence in interacting with patients who may come from various cultural backgrounds. Medical practitioners need to recognize how patients understand their illness and its causes. Patients may exhibit verbal and nonverbal behaviours, the meanings of which should not to be taken for granted, as these meanings may be culturally specific. Although medical practitioners do not have to agree with their patients' health beliefs, they should acknowledge and respect the patients' 'illness experience' beyond the confines of a biomedical system (Flynn et al., 2014).

So far, research on medical practitioner-patient communication is more likely to be based on patients' perspectives (see for example Boot et al., 2009; Hawthorne, 2006; Park & Song, 2004). We suspect that medical practitioners have similar concerns

regarding these barriers, but may have different views which must be understood.

LITERATURE REVIEW

Medical Practitioners – Patient Communication

Communication between medical practitioners and patients is a complex process. As suggested by Edelmannn (in Berry, 2007), in most cases clinical interaction could be considered as communication between two different cultures: the medical culture and the patient culture. On the one hand the patients are expected to be open and frank, and on the other hand medical practitioners are demanded to be trustworthy and reliable. Medical practitioners are expected to have the ability to open a conversation with the patient by actively listening and showing empathy, while patients are required to be proactive and cooperative in their treatment, and to put their trust in the medical practitioners. As such, barriers of communication between both sides are inevitable, no matter small they are.

Lubinski and Welland (in Park & Song, 2005) stated that some barriers related to stereotyping, as well as the lack of competence in understanding basic medical termimonology. Hie (in Pramujiono, 2008) referred to four factors that led to ineffective communication between medical practitioners and patients: (1) economic factors; (2) factors relating to the perceived "arrogance" of medical practitioners, who perceive their patients to be ignorant about health; (3) communication competence factors between medical practitioners and patients; and (4) aspects of patient behavior: for instance asking questions that exasperate the medical practitioners.

Hardee and Platt (2010) found four communication barriers between medical practitioners and patients: (a) lack of time; (b) 'pandora's box': a situation where a patient vents his/her emotions (sadness, fear, frustration, depression, etc) to the medical practitioner; (c) burn out: a situation when medical practitioners feel overwhelmed, frustrated, and tired as a result of the large number of patients requiring treatment; and (d) not knowing what to say; that is, medical practitioners just do not know what to say when responding to patients' problematic ideas, feelings, and values.

Medical practitioner-patient communication styles affect a number of patient behaviors and outcomes, including physiological outcomes, compliance to treatment, and, most importantly, patient satisfaction with care (Dutta, 2009). Research shows that better communication has led to better health outcomes, higher levels of satisfaction, lower stress and anxiety, increased compliance, better understanding of treatment risks, shorter hospital stays, and fewer medical errors and malpractice lawsuits (Berry, 2007; Eckler et al., 2009). Having accurate information about a patient is crucial to diagnosing his/her illness and deciding on the appropriate course of treatment. Through communication, patients can vent their problems, which in itself is a form of healing (Hardhiyani, 2013). In their study of families with children

suffering from cancer in a Jakarta hospital, Rahmawati et al. (2017) indicated that the satisfaction of families was connected with the efficacy of the medical providers' communication when dealing with their clients. The result indicated that 56.5% of the respondents were satisfied with the therapeutic communication provided by nursing staff; those who practiced therapeutic communication well were 22 times more likely to be deemed satisfactory by families of child cancer patients, as compared with those who did not apply good therapeutic communication.

Communication between medical practitioners and patients who come from different cultures is more difficult and challenging. When medical practitioners and patients are from the same culture, medical consultation lasts longer, and patients behave more favourably towards medical practitioners (Haskard et al., 2009). Hughman (2009) contended that effective therapeutic communication required medical practitioners to be aware of the intercultural prejudices in themselves as well as in others. He warned us that members of the dominant ethnic group might regard themselves as superior, while considering others inferior in terms of intelligence and rationality. Such a situation may create friction between medical practitioners and patients, as found by Priebe et al. (2011) in their study in Europe. The study indicated eight obstacles that medical practitioners and patients were often faced with (1) language barrier, which included misinterpretations likely to occur, in spite of the provision of hospital translators; (2) problems relating to patients whose healthcare was not facilitated by the government; (3) dealing with patients who had suffered traumatic experiences; (4) dealing with patients who were not aware of the health system; (5) comprehending illness and treatment differently; (6) different expectations of proper medical examination and treatment because of different cultural and religious backgrounds; (7) negative attitudes of staff toward patients, and vice versa; and (8) the lack of access to medical records.

A more recent study (Clough et al., 2013) found that four barriers faced by Asian migrants to engaging in the U.S. health care system were: (1) language differences between providers and patients; (2) beliefs about health and cultural incompetency of health systems; (3) accessing health services; and (4) discrimination in the healthcare system. More specifically Taylor et al. (2013) examined medical professionals' perceptions of healthcare barriers encountered by people from ethnic minorities in the United Kingdom who had poor or no English language skills. They found the following barriers: (1) language; (2) low literacy; (3) lack of understanding; (4) attitudes, gender attitudes and health beliefs; and (5) retention of information.

Theoretical Framework

Medical practitioners and patients interact symbolically, whereby each of them interprets the verbal and nonverbal cues, which are interpreted differently by both sides. Humans are creative in their use of concepts

and labels. In Berger and Luckmann's (1966) theory of social construction, the patient's illness is a symbolic interplay between the medical practitioners' consciousness and consciousness of the patient. Knowledge of the illness is negotiated between the medical practitioners and the patient. In other words, "people interpret and make meaning of bodily, physical, and psychological states often in very culturally specific ways" (Ho, 2015).

Working from the assumption that one's illness is a social construction, it can be deduced that there is no single true reality; rather, reality may be interpreted differently by the medical practitioners and the patient. Based on this phenomenological stance, language is used to negotiate the illness by both parties. They are continuously involved in the production and reproduction of the meaning of the illness, as expressed in their verbal and nonverbal communication with each other. Using the social construction theory, individuals with different social and cultural backgrounds, including medical practitioners themselves, may attribute different meanings to the same ailment. Different medical practitioners may perceive similar symptoms differently, and hence offer different solutions.

Any research that considers the subjective position of human beings and reveals personal experience, is what is usually referred to as the phenomenological approach. In this instance, the focus of our research is the medical practitioners' experience. When encountering a patient, symbolic interaction occurs between the medical practitioner and the patient, just as a symbolic interaction also occurs between the medical practitioners as informants, and us as researchers. The researchers interpret medical practitioners' narratives concerning the barriers they have experienced in dealing with their patients, then categorize them into new patterns or themes, which approximate what Schutz (1962) called 'the second-degree constructs.'

According to the symbolic interaction theory as formulated by George Herbert Mead (Mulyana, 2001, 2012) which is a variant of the phenomenological perspective, the exchange of symbols that are given meanings is an important characteristic of human activities. Symbolism does not only include language but also every aspect of human actions. This is not a new idea, even though sholars of symbolic interaction put language in its own special place. The essence of this theory states that humans are highly active and dynamic beings and are capable of interpretting both their own experience and the experiences of others.

METHOD

In line with this perspective, the method used in this research was a qualitative one based on a phenomenological perspective with semi-structured interviews. It explored a phenomenon in detail that was experienced by the individuals in their everyday life. It concluded with a description about the essence of 'what' they had experienced and 'how' they had experienced it.

Littlejohn and Foss (2005) described how every individual interpreted his/her

own life experiences, until at a certain point in life when he/she understood the world, or 'life', from his/her personal experiences. The process of acknowledging these experiences is a basic tennet of phenomenology. Creswell (2013) noted some defining features of a phenomenological study: He stated that a phenomenon that was experienced by individuals must be explored and discussed thoroughly. The interview data should be analyzed thematically (Miles & Huberman, 1994). The themes ought to be related to the way medical practitioners, as the subjects of the study, described their life experiences including their careers; the way they communicated (including specific terms that the actors used to describe their life experiences and their communication practice); and the way they used their knowledge and experience in managing communication and making decisions. More specifically, the study had selected and focused on the core theme, that was, communication barriers beween medical practitioners and their patients. It is this core theme that was analyzed and functioned as guide to produce the research results.

For the purpose of this research, namely, to identify communication barriers medical practitioners experience when dealing with their patients, we had interviewed 28 medical practitioners. These informants consisted of 19 medical specialists (one surgeon, two orthopedic specialists, three internists, two neurologists, one dermatologist, one radiologist, one ophthalmologist, two nutritionists, one beauty specialist, one orthodontist, and four dentists), as well as nine general practitioners. In terms of gender, we interviewed more female informants than male ones. Their ages ranged from 28 to 69. They belonged to several ethnic groups: Sundanese, Javanese, Batak and Minangkabau, among others. These medical practitioners had all experienced similar phenomena, which had involved encountering barriers to effective communication with their patients.

The data collection technique used in this research involved semi-structured interviews. This technique is crucial in qualitative research, enabling the gathering of data which are both complete and accurate. The fieldwork lasted from June 2016 to March 2018. The duration of each interview varied from 20 minutes to one hour, several medical practitioners were interviewed twice, owing to the variable availability of each informant. In many cases it was difficult to make appointments due to family and work commitments of the informants.

RESULTS AND DISCUSSION

As a result of our interviews with the 28 informants, which focused on communication barriers between medical practitioners and patients, several categories of communication barriers emerged, as follows:

Cultural Differences Barrier

Every culture has a distinct perspective of effective healthcare treatment and its ethicality (Lloyd & Bor, 2009). Conceptions of health and illness are influenced by

cultural, ethnic, religious gender-related beliefs and values, and even their family upbringing (Schiavo, 2007). In our research, it was observed that different cultural backgrounds also constituted one of the main barriers to effective communication between medical practitioners and patients. Medical practitioners and patients may come from a diverse range of cultural backgrounds, and may belong to different racial, ethnic and religious groups. Research indicates that medical practitioners' intercultural communication competence is related to their level of empathy, bilingualism, and intercultural experience (Gibson & Zhong, 2005).

In Indonesia, it is common for medical practitioners to be mobile throughout the country. They may move from one city to another, and from one hospital to another. Many medical practitioners have to carry out their compulsory duties in remote areas in their early career. They have encountered patients from various cultural backgrounds. "Chinese patients and their families usually ask detailed questions", said DJR, a Javanese neurologist. Meanwhile, BEN, a Batak orthopedic specialist said:

> Every ethnic group has a unique character. We have to deal with Chinese, Batak and Sundanese differently. When we deal with the Batak, from the beginning we have to be open and straightforward. We have to tell the Batak patients what their illness is, the diagnosis, and the plan for treatment, because their culture is like that. Even regarding the cost, we have to tell them frankly, otherwise there will be a problem. As for Javanese patients, as with Sundanese patients, they are usually more cooperative.

When a medical practitioner tries to explain how the patient can recover from a disease or illness, patients are often reluctant to implement the medical practitioners' advice due to their cultural beliefs and values. Such cultural beliefs and values are often connected with superstitions, or paternalistic values they inherit from their forebears. As informants admitted, in some cases people do not really trust in medical practitioners; rather, they prefer to go to *dukun* (shaman). Here are some informants' experiences that relate to cultural differences with their patients:

1. A dentist recommended that a patient's tooth be pulled out, but the patient refused, because the patient was worried that, according to a myth, the procedure would cause him to go blind.
2. A dermatologist reported that a child suffering from diarrhea was given an amulet by the parents and was placed in the living room rather than in the bedroom in order to recover, according to the parents' superstitions.
3. An orthodontist asked her assistant to provide tea for a patient who had fainted. The assistant said that it could not be done, as tea was prohibited by the patient's religious beliefs, as a Seven-day Adventist.

4. An ophthalmologist reported that occasionally, when a patient needed immediate surgery, treatment was often blocked by the family, who insisted on seeking permission from a family member in a distant village

Language differences are another specific form of cultural barrier from the category cultural backgrounds. Waitzkin (2009) suggested that intercultural and language differences in communication patterns, created barriers in provider-patient communication that might lead to a misunderstanding of somatoform symptoms. When medical practitioners and patients do not speak the same language, the situation becomes more problematic (Valero-Garces, 2014).

Some informants admitted that in their early careers as general practitioners they required to go to remote villages, where the community had their own language and rarely use the national language (Indonesian). It has thus become common that when a medical practitioner tries to communicate with a patient, neither is able to understand the other due to the language barrier. Some informants explained that they sometimes needed a translator, the translator usually being a member of the patient's family who could speak Indonesian fluently, or a nurse who came from that village. However, in some cases, informants had eventually learned the local language. ST, a general practitioner, said, for example, "I learnt to speak the language in Cirebon by just doing it". Similarly, M, a dentist, said "When I was in a remote place in Bengkulu, communication was an obstacle. Because patients only spoke their local language, which I did not understand. My assistant helped me to communicate with them".

The Barriers of Educational Differences

This study shows that both patients with higher educational and lower educational backgrounds are often ignorant of their health issues. Many patients prove not to understand how to maintain basic health. For example some dental patients are not aware of the need to have a routine check up every six months. These patients usually come to the dentist only when they are already experiencing toothache; when the toothache stops, they think that they have recovered and do not need to visit the dentist anymore. The reality is that it will cost them more money if they wait for the toothache to reoccur, as opposed to having a routine check up in the meantime.

Furthermore, patients sometimes stop taking their antibiotics when they start to feel better, and do not complete the full, prescribed course. This suggests that they do not understand how antibiotics work. DV as a general practitioner explained:

> Patients don't understand that, for instance, when they suffer from TBC, they need to take a six-month course of medicine. Because they don't understand this, they often stop consuming the medicine when they start to feel better, which will eventually result in a recurrence of the disease.

Educational differences in other cases showed that the informants, in their role

as medical practitioners, sometimes have difficulties in explaining a disease or illness due to the low level of education of some patients. Patients usually have difficulty understanding medical terms, which often stems from their low educational background. NF, a general practitioner stated:

> I am sorry to say that perhaps patients never go to school, or are only primary school educated. Sometimes they will continue to misunderstand my explanation, despite me having already explained in detail. If the patient was a teacher or a university student, it would be easier to educate them.

Some informants stated that most patients demanded clear and detailed information about their illness, but then because of their low educational background, they could not comprehend what was being explained. In this case, it is clear that the informants, being medical practitioners, need to have the ability to explain medical matters to the patients in the simplest possible terms. ST, a general practitioner, shared an experience in which she had had a discussion with a man whose son was diagnosed with HIV. The man had no idea what HIV was, and was not at all shocked, assuming that it was just a normal illness such as a common cold, from which his son would soon recover. “Patients with low educational backgrounds present a big problem for us as medical practitioners”, said ST.

Another case that causes difficulties, is unaccompanied patients. Patients often rely on a friend or family member to relate their medical history when they are too sick to communicate themselves. Even when the patient has a companion, if the companion is also from low educational background, he or she may be unable explain the patient’s medical history adequately. This is a serious barrier, because it can render the medical practitioners unable to act quickly and decisively. In such cases, medical practitioners then require more time to further examine his or her patient’s condition.

On the other hand, dealing with a patient with a higher educational background can also prove problematic. One informant stated that patients with higher educational backgrounds are sometimes prone to underestimating the advice of medical practitioners. The patient may think of himself or herself as being more knowledgeable about his or her own health than the medical practitioner.

Time Barrier

This research confirms one of the barriers of medical practitioner-patient communication as observed by Hardee and Platt (2010), namely, time barrier. In this particular case, it is an administrative barrier inolving patient waiting times. Some informants claimed that the number of patients queuing throughout a day can be overwhelming, and consequently became a barrier to effective communication with patients. They claimed that long queues resulted in ineffective communication with their patients. Conversely, patients who were aware of the medical practitioners’ time

constraints were liable to lose their trust in them, and might experience difficulties being completely open, as a result. "When the queue of patients is too long, we become overwhelmed, and we appear to the patients to be robots", said VY, a general practitioner. VY explained that when she dealt with patients, the medical history of whom she was already familiar, it did not really take much time. On the other hand, for new patients she needed much more time. Such medical examinations are made more difficult by the knowledge that a long queue of patients is waiting outside.

Time also became a problem for SSK, a nutritionist. She said:

> To find out about a patient's daily eating habits, we must let them them speak. They may be defensive and claim that they eat very little, but that their body weight continues to increase. So I might say, "You know better than I do the reasons why your weight is increasing." We often need to have a chat with them first, in order for them to admit what they have actually done.

In the same vein, NF, a general practitioner, stated:

> Communication [between medical practitioner and patient] must be two-way, and mutual. Two minutes is not enough; however, it is impossible to have such communication in *Puskesmas* [Community Medical Center], because there are too many patients.

AS, a dentist also reported the time barrier as a communication barrier:

> Patients find it difficult to visit the dentist on a regular basis, wanting instead to visit only once, and for everything to be done. They need to be aware of the necessity of control and reexamination, without waiting for the pain to reoccur.

Psychological Barrier

Medical practitioners, like any other human beings, suffer 'mood swings' that can sometimes affect the way they perform their duty. Occasionally, they can find themselves overwhelmed by the sheer number of patients, and become tired and hungry. One medical practitioner admitted that in the run-up to lunchtime, it became hard for her to concentrate, and she found herself wondering about what to have for lunch. Similarly, by the end of the working day, she found she had less interest in listening to patients, or communicating with them; all she wanted was to go home.

The most common problem related to the psychological barrier was the unwillingness of patients to cooperate with their medical practitioners. SB, an internist, reported that there were sometimes patients who, because they were rich or able to pay, wanted to dictate the course of medical examination and treatment, despite knowing little about the purpose of the examination and the medication.

AYLA, another internist, related an experience in which a patient, who was passive remained silent throughout his consultation, despite being given adequate time to express his complaints. He also

described a patient who returned to see him, after two years, in a worrying condition. It turned out that the patient had not followed the medical practitioners' advice and had not paid sufficient attention to his condition. The patient returned only after his condition had worsened. Similarly, HNR, an orthopedic specialist, related that he had consulted a patient who remained silent, said little when asked, and looked scared. SSK, a nutritionist, reported a patient whose body weight continued to increase, despite her claims that she did not eat much. However, the patient finally admitted that she ate a lot of snacks between meals, including meatballs. SSK also related well-educated patients who were knowledgable and well-informed regarding their illness. "They did not always follow our advice", said SSK.

In another case experienced by CN, a dentist, she reported, "A stubborn man only wanted treating according to his wishes. He said, 'pull out this tooth!" despite the fact that the tooth could be treated without being pulled. In another case, AR, an orthodontist advised her patient that it was necessary to pull her tooth, but the patient refused the orthodontist's advice. In the end she filled the tooth, according to the patient's wishes. However, some time later the patient returned with toothache.

The four barriers delineated above are notable communication barriers beween medical practitioners and patients. Of these four barriers, the cultural barrier is the most significant, followed by the educational differences barrier, then by the time barrier, and finally the psychological barrier. However, while existing independently, none of these barriers are mutually exclusive; on the contrary, they are actually closely related. For example, language is a key element of culture, and one's mastery of language is connected with one's level of education. Indonesian may not be properly mastered by some patients because of their low educational opporunities. This educational gap, and the importance of a shared language, is considered a major 'homework' for medical practitioners, mainly in small villages throughout the country.

Figure 1 is a model of communication barriers as experienced by the medical practitioners as our informants in communicating with their patients.

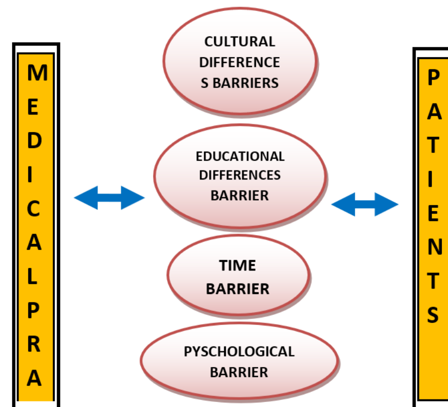

Figure1. Communication barrier model between medical practitioners and patients

CONCLUSION AND RECOMMENDATION

Based on the analysis of the data collected from semi-structured interviews with 28 medical practitioners, it can be concluded that the barriers that the medical

practitioners experienced affecting their communication with their patients are: (1) Cultural Differences Barrier; (2) Educational Differences Barrier; (3) Time Barrier; (4) and Pychological Barrier.

It is not our purpose to generalize these research findings to all other medical professionals due to the limited number of the informants, and the interpretive perspective that is used in this study. Further research comparing other specific group of medical professionals (whether they be medical specialists, general practitioners, midwives, or nurses) in the way they communicate with patients and other medical stakeholders, such as hospital managers and medical company representatives are also worth pursuing. These studies should be based on various theoretical perspectives and different research methods in order to gain a holistic picture of the medical world. Even a hospital or a medical school, in terms of its communication patterns or communication processes, is an appealing subject for futher investigation from an interpretive perspective. Perhaps the most interesting research issue to investigate is the cross-cultural barriers between medical practitioners and patients, as Indonesia is a broadly multicultural country that incorporates a wide variety of cultural groups (racial, ethnic, linguistic, religious, gender-related, educational, and class) and various subcultures. Indeed, one limitation of this study is that it involved only physcians and not patients. In this context, to gain a more complete picture of communication barriers between medical practitioners and patients, in the future it is important, if not essential, to interview patients from a variety of ethnic and cultural backgrounds.

In the meantime, it is worthwhile to enhance the medical practitioners' communication skills in dealing with the patients. Specifically, medical practitioners need to attend more workshops on effective communication strategies; medical practitioners need to be aware of the different social-cultural backgrounds of patients and to be competent in dealing with problems related to their communication with patients; finally, the government should be aware of the role that the overall lack of education in Indonesia plays in the health of it citizens, and make necessary efforts to minimize the tendancy of many Indonesians to neglect their health.

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