

## Communication Barriers Between Patients and Healthcare Providers

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### Abstract

This study aimed to assess the prevalence of communication barriers between patients and healthcare providers at Bethlehem and Hebron health care centers. The study used the quantitative approach, using a questionnaire, which is appropriate for the exploratory nature of the research. Therefore, three hundred sixty-eight health care providers were stratifiedly selected, based on gender and Governorate. The sample size was calculated using the sampling web of <http://www.surveysystem.com/sscalc.htm>, sample size calculator, with a margin error of 0.05. To achieve this end, a 25-item scale was used to measure communication barriers between patients and HealthCare Providers as perceived by HealthCare Providers, that was developed by the research team, based on Norouzinia *et al.* (2016) scale, taking into consideration the cultural appropriateness in the Palestinian society. A 5-point Likert scale (ranging from strongly agree to strongly disagree) was used to measure responses. The collected data was statistically analyzed using the statistical package for social sciences (SPSS). The study found a moderate level of communication barriers between patients and healthcare providers. Moreover, findings showed that gender, qualification and division do not show any significant differences. While the differences in authority variable were in favor of the Governmental participants, as for work shift, the differences favored participants in shift A, and regarding the profession variable, the differences favored to the doctors. The study recommends the providing of training sessions for healthcare providers with different ages in communication skills. In addition, the ministry of health in Palestine should take into consideration the workload of the healthcare providers, by employing additional number of healthcare providers.

**Keywords:** Communication, communication barriers, Healthcare Providers, patients, Palestine.

## 1. Introduction

Communication is a multifaceted, multifactorial phenomenon as well as a dynamic, complex process that is directly influenced by the setting in which one shares experiences. Specialists and nurses have focused a lot of attention on interaction and communication in nursing from the 19th century to the present. The quality of the nurse-patient connection is enhanced through effective communication, which also has a significant impact on the patient's perceptions of the treatment's effectiveness. The cornerstone to providing high-quality nursing care is effective communication, which promotes patient satisfaction and wellness. Healthcare providers' ability to communicate effectively is essential for providing quality care, which helps reduce symptoms of anxiety, guilt, discomfort, and sickness (Vermeir *et al.*, 2015).

Healthcare providers can improve the patient's physiological and functional state and promote patient happiness, acceptance, compliance, and cooperation with the medical team. This has a significant impact on the patient's training as well (Shouten *et al.*, 2020). But, the majority of research have noted problematic healthcare providers-patient relationships (Chichirez & Purcărea, 2018). In conclusion, patient-healthcare providers dialogue has not generally resulted in personal satisfaction. This is because the healthcare providers-patient connection has a significant impact on the quality of healthcare, and poor communication skills (or the failure to use them) has a detrimental effect on the services offered to patients. The findings of earlier studies have demonstrated that although nurses have received training in effective communication, they do not apply these abilities when interacting with patients in clinical settings (Li *et al.*, 2017).

According to the findings of other studies, nurses and nursing professionals as a whole have not put much effort into developing pleasant interactions with patients. Numerous reported issues are linked to hospital staff members' diminished feeling of altruism, particularly nurses (Bridges *et al.*, 2012).

Therefore, the current study will try to find out the prevalence level of communication barriers between patients and healthcare providers, due to the importance of communications skills of the healthcare providers among the interaction with patients. Which considered the most important element of the relationship between patients and healthcare providers.

## 2. Background And Literature Review

Achieving successful healthcare outcomes requires effective communication between patients and healthcare providers. Application of language and behavior to create, send, and interpret messages is known as communication (Al-Kalaldehy *et al.*, 2020). One of people's basic social requirements is communication, along with making positive connections (Anoosheh *et al.*, 2009). The environment affects communication because it entails interaction between the speaker and the listener. Any obstacles to these three criteria can lead to unsuccessful communication because they all influence the outcome of communication (Norouzinia *et al.*, 2015).

### 2.1 Importance of HealthCare Providers Communication With Patients

The effectiveness of communication between nurses and patients is a crucial factor in patient satisfaction that has been mentioned in numerous research. In the nursing field, communication is essential and is seen as one of the primary nursing tasks. Many nursing theorists have highlighted the significance of nurse-patient relationships in recent years. It has been asserted that every definition of nursing mentions the relationship between nurses and patients, emphasizing that this relationship is necessary for nursing to occur (Alshammari *et al.*, 2019). Additionally, the "privileged nurse-patient relationship" is described as a distinguishing feature of nursing (Alshammari *et al.*, 2019).

A nurse may fail to develop a relationship with a patient, develop a relationship that has a negative impact, or develop a therapeutic relationship that is positive and beneficial (Roodbeen *et al.*, 2020). Communication might be seen as the primary means of delivering care because it is so crucial (Schallmo *et al.*, 2019). Healthcare personnel can create the right environment for effective communication to promote patients' perceptions of being heard and cared for. This environment includes a suitable one (e.g., private, comfortable), enough time to digest information and emotions, and the presence of the patient's designated support network (Schouten *et al.*, 2020).

However, patients believe that speaking with nurses is crucial to their recovery (Sun & Rau, 2017). The importance of effective communication in nursing care has been highlighted by patient-oriented methodologies. The nurse-patient relationship was stressed by Laukka *et al.* (2020) as "not only a vital aspect of nursing care but also as a treatment by itself". Effective communication is important for these patients' wellbeing, according to (Ilardo & Speciale, 2020), thus in this context, the word

"functional communication" can be used to denote successful communication as judged by the patient and nurse.

However, numerous studies have revealed subpar outcomes in the degree of contact between nurses and patients. The development of a desirable relationship has been hampered by structural factors despite the focus on nurses' communication skills over the past two decades, and there is a danger that nurses may become even more preoccupied with practical concerns and physiological needs at the expense of psychological needs. Patients got irritated when they were unable to transmit crucial messages, and there is a risk that identity is not validated, according to a previous study by Vitale *et al.* (2021).

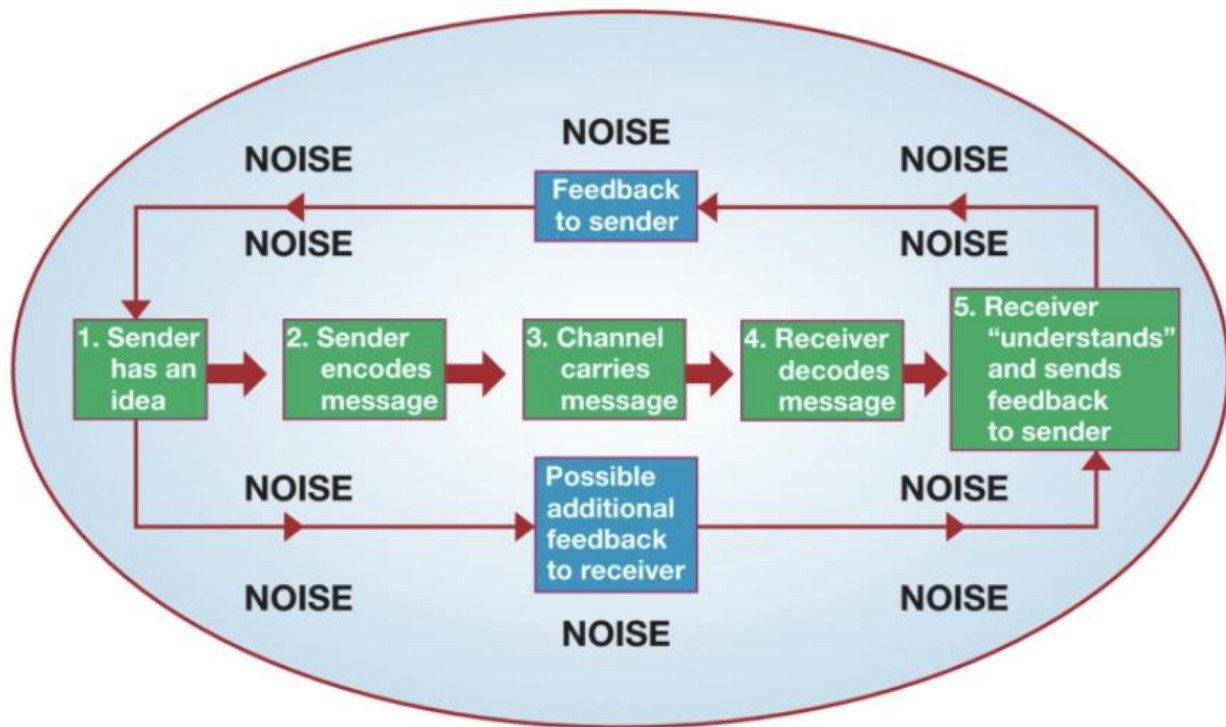
Since communication is a two-way engagement, it is more useful to look at how both patients and nurses perceive communication difficulties. The first step in resolving a communication issue should be to comprehend the other party's perception of the barriers since effective communication is impossible without a thorough awareness of the other party's perceptions (Vermeir *et al.*, 2015).

## 2.2 Communication Skills Needed Between HealthCare Providers And Patients

Every healthcare provider needs a certain level of effective communication skills because it is the cornerstone of high-quality patient care and safety. The team that healthcare provider works with and patients will benefit from the effective communication skills, which will improve patient outcomes and create a productive workplace (Chichirez & Purcărea, 2018).

There is a level of meaning that is loaded into each message during a communication exchange. Nevertheless, for a transfer of communication to be successful, all parties must agree on the meaning of what is being said (Al-Kalaldeh *et al.*, 2020).

A skilled communicator would also take into account any potential cultural or physical barriers that can inhibit or obstruct communication. The communication process, according to McCorry & Mason (2020), can be broken down into five steps:



Source: Mccorry & Mason (2020). Communication skills for the Healthcare Professional. Enhanced Edition. Jones & Barlett Learning.

## 2.3 Barriers of Communication Between HealthCare Providers And Patients

One particular impediment to communication, among many others, is health literacy. Health literacy is a skill that only 12% of adults possess, and it is well known that patients with low health literacy struggle to comprehend written medical information, communicate with healthcare professionals, and follow self-care recommendations (Li *et al.*, 2017).

Additionally, the national nursing exam tests communication skills, and both comprehension of inadequate health literacy and communication skills are prerequisites for resident education. Although recent research has indicated that system-wide communication skills training for faculty physicians can increase patient satisfaction scores and combat low health literacy, these results have not been examined in the populations of residents and healthcare providers (Sun & Rau, 2017).

Patients' concerns regarding their health and wellbeing are understandable. Effective communication is hampered by a number of factors, including:

- Time limitations.
- Environmental issues such as noise and privacy.
- Pain and exhaustion.
- Embarrassment and anxiety.
- Use of terminology.
- Values and beliefs.
- Information overload (Li *et al.*, 2017).

### 2.3.1 Time Limitations

For nurses, communication is significantly hampered by time or a lack thereof (Norouzinia *et al.*, 2015). Although hurried communication is never as efficient as a leisurely engagement, nurses working under pressure may overlook the quality of communication when presented with conflicting expectations. Remember that communication does not have to take a lot of time a simple smile, a hello, or some "small talk" about the weather may be enough. Even if there are no urgent updates to share with any particular patients, spending the time to get to know them can help set the stage for any future unpleasant conversations that may need to occur (Al-Kalaldeh *et al.*, 2020).

Because of the demands of other patients, such as the need to respond to an emergency or provide pain relief, interactions between patients and nurses at a busy hospital may be delayed or interrupted. Patients who may feel neglected by this situation may find it frustrating. If there are disruptions, it's crucial to let the patients know why you have to leave. It may be sufficient to reassure them that you understand their concerns are vital to make plans to return in a certain amount of time (Alshammari *et al.*, 2019).

### 2.3.2 Environmental Factors

Healthcare professionals may be so accustomed to their surroundings that they are oblivious to the elements that can hinder communication. In a crowded clinic, background noise can impair patients' hearing, and some may try to hide this by nodding and "appearing" to hear. If medical professionals believe a patient has hearing issues, they must lower background noise, look for a quiet area, or enter a quiet office or side room (Bridges *et al.*, 2012).

Communication with patients might be hampered by noise and other distractions. If a patient is questioned about their clinical history in an environment where others can hear them, such as a crowded reception desk or a cubicle with only a curtain for privacy, they can be reluctant to share sensitive personal information. It's crucial to refrain from asking private questions when patients' answers might be overheard by others. If requesting the patient to fill out a written form is not an option, keep in mind that certain patients may have difficulty with reading and writing and may require the form to be delivered in a foreign language or be translated for them (Schouten *et al.*, 2020).

### 2.3.3 Embarrassment And Anxiety

The shame of patients and medical staff may lead to unpleasant interactions that may impede efficient communication. But awkward interactions can be made easier by preparing for potential humiliation, minimizing it, and adopting plain, open communication. For instance, in a clinic, a patient would be required to take some clothing off for a checkup. Being clear and precise is crucial. When given with matter-of-fact assurance, clear instructions can reduce stress and embarrassment (Schallmo *et al.*, 2019).

Patients may worry that by referring to anatomical features or biological processes inappropriately, they would disgrace medical professionals or even themselves. Many individuals experience anxiety before having intimate procedures like bowel and bladder examinations. In addition to informing patients what to expect, explaining any adverse effects of procedures, such as flatulence or vomiting, assures them that the personnel will not be insulted if these occur (Al-Kalaldeh *et al.*, 2020).

### 2.3.4 Use of Terminology

Technical terminology and clinical acronyms should not be used with patients, even though they might be a useful communication tool for professionals in the same field. They might not ask the healthcare professionals for a clear English translation even if they might not comprehend. Terminology is simple to use without recognizing it (Li *et al.*, 2017).



### 2.3.5 Pain And Exhaustion

When patients are extremely unwell and agitated, healthcare providers frequently need to get crucial information from them, yet symptoms like pain can impair focus. It's critical to address pain and discomfort when gathering information quickly: "I know that this is painful, but it's crucial that we talk." Additionally, patients may be exhausted from a restless night, sleepy following an anesthetic, or experiencing medication side effects (Norouzinia *et al.*, 2015).

### 2.3.6 Values And Beliefs

On the basis of their societal or cultural views, values, traditions, biases, and prejudices, everyone makes assumptions. Patient perceptions that a guy cannot be a midwife or that female staff members must be juniors are both plausible. It is crucial to be aware of patients' presumptions since they may cause them to misinterpret, reinterpret, or even ignore what medical professionals are telling them. An assumption made by a healthcare professional could be that a patient in a same-sex relationship won't have children, that a patient who is Asian won't speak English well, or that a patient has a learning issue (Schouten *et al.*, 2020).

### 2.3.7 Information Overload

Patients and other non-patients find it difficult to take in a large amount of information at once, and when they are inundated with numbers, information, and choices, it is simple to forget about them. This is especially true for patients who are angry, disturbed, distressed, worried, exhausted, shocked, or in pain. If medical professionals need to give a patient a lot of information, they must first gauge how the patient is feeling and just address the important topics (Vitale *et al.*, 2021).

## 3. Related Previous Studies

Previous studies have emphasized on the importance and consequences of assessing the barriers that prevent the effective communication process between patients and healthcare providers. Shooten *et al.* (2020) conducted a study aimed to enhance intercultural communication and healthcare for migrant and ethnic minority patients, a more holistic approach. The study used the descriptive analytical approach, in which it used the content analysis of the previous studies and literatures related to the topic of the study. Thus, the study followed the qualitative method. In it



results, the study showed that in order to handle with language barrier such communication strategies might be employed as interpreters, digital translation tools and multilingual eHealth applications. In addition, the study showed that decreasing cultural barriers in healthcare communication requires a shift from patient-centered to more family-centered communication. Moreover, the study recommended to include all stakeholders in interventions toward improving intercultural health communication with ethnic minority and migrant patients.

Furthermore, Roodbeh *et al.* (2020) aimed in their study to explore the communication and shared decision-making with patients with limited health literacy; helpful strategies, barriers and suggestions for improvement reported by hospital-based palliative care providers. In this context the study used the interview with healthcare providers, in 4 Dutch hospitals in 2018. The data were analyzed using thematic analysis. The results showed that the healthcare providers have conception of the literacy of patients, but they do not taking into consideration the health literacy. In addition, there are 5 barriers considered by healthcare providers into communication with patients: time management, healthcare providers' communication skills, information delivering, patients characteristics, and the health information.

Al-Kalaldeh *et al.* (2020) conducted a study aimed to identify what emergency nurses perceive as barriers to nurse-patient communication, and if there is any difference in the perception of communication barriers between nurses' demographic subgroups. 199 nurses at emergency department in 9 hospitals in the West Bank have been participated in this study, using the convenience sampling technique, they completed a 27-item questionnaire that encompassed six domains of barriers that may affect nurse-patient communication. The study found that the environmental factors scored the highest, meaning that emergency nurses perceived these to be the most significant barriers to effective nurse-patient communication. This was followed by knowledge-related and psychological factors.

In another cross sectional study conducted by Fite *et al.* (2019) that aimed to determine the effective implementation of therapeutic communication and its predictors, one hundred ninety two patients have been participated in the study, using the stratified sampling technique, using a questionnaire to collect data. The study shows that (34.9%) of the patients rated high level of therapeutic communication. Moreover, significant predictors of therapeutic communication implementation were educational status, language difference, education difference, and perceived patient view.

In a study conducted by Schallmo *et al.* (2019) aimed to conduct an integrative review to evaluate how healthcare providers perceived communication barriers to offering information to individuals in the palliative phase of heart failure. The study depended on reviewing the previous literatures related to the topic of the study, since 1987 until 2017. The results showed that the lack of knowledge about palliative care by healthcare providers considered as barrier into the communication process with patients. In addition, the results showed that the barriers of communication process mainly lack of patients awareness about healthcare knowledge, and workload of the healthcare providers.

Moreover, Lotfi *et al.* (2019) conducted a study aimed to assess nurse–patient communication and patient's satisfaction from nursing services in the burn wards of women and men. The participants of the study are all patients admitted to the Burn wards at the Sina Hospital. The study used the descriptive approach, and using the questionnaire toward gathering needed data. The study has revealed that most patients were dissatisfied with nursing care. In addition, more than 80% did not know their nurse. Although, there was a correlation between nurse-patient communication and patient satisfaction with nursing care and the sex variable. The study recommended the improving of the satisfaction of patients in the hospital should be the priorities of the hospital managers. Therefore, by educating staff, especially nurses, identifying motivating factors as well as identifying dissatisfaction factors, improved patient satisfaction.

A systematic review study of Kiani & Ahmadi (2019), aimed to investigate the barriers and facilitating factors concerning communication among healthcare workers. The study depended on literatures published in PubMed, Scopus, Web of Science, MagIran, Iranmedex, Google Scholar, and SID databases from 2008-2018. Accordingly, the study found that “pleasant greetings” and “tidy appearance” were the most important factors facilitating the patient-physician relationship. However, the most important barriers to communication in the clinical setting were “poor introduction of the healthcare provider to patients”, “high workload and fatigue”, and “lack of training on the principles of communication skills and environmental factors”.

Li et al., (2017) conducted a study aimed to analyze the verbal and nonverbal barriers to effective communication with Limited English Proficiency, and proposing strategies to mitigate the barriers of communication. The study followed the descriptive analytical approach, by using the content analysis of previous literatures directly related to the subject of the study. The results showed that most of the initiatives adopted related to three categories: continuing education on serving Limited

English Proficiency patients for health professionals, authorization of healthcare interpreters, and compensation for language services for healthcare attendees. The study recommended that there is a must to inform all Limited English Proficiency patients about their legal rights, the resources available to them, and the actions they can take. In addition, the study proposed to add more two strategies: to increase awareness of barriers related to verbal and nonverbal barriers to cross-cultural communication, and to increase multi-cultural competencies of health providers.

While the purpose of Sun & Rau (2017) study was to evaluate Chinese physicians' performance of communicating with patients in a primary care setting, and to discuss barriers to improving physician–patient communication from physicians' perspectives. The study used the observations within communication assessment checklist with 7 healthcare centers, after that the study depended on in-depth interviews with physicians. The study achieved number of results, in which the most important were that Chinese physicians are poorly communicators with patients, in addition to the styles of communication that physicians used are based on their experience and personality. Moreover, the barriers of communication represents in four barriers: the less health knowledge by patients, the workload of healthcare providers (physicians), the lack of awareness in communication skills by physicians, and the defensive behaviors adopted by physicians.

Finally, Norouzinia *et al.* (2015) conducted a cross sectional, descriptive analytic study, in which its purpose was to identify the communication barriers observed by nurses and patients. The number of participants in the study was 70 nurses and 50 patients in two hospitals belong to Alborz University of Medical Sciences. The study depended on two separate questionnaires, which one for nurses and one for patients. The study revealed that in both nurses and patients' questionnaire, the nurse-related factors and common factors between nurses and patients were considered the most and least significant factors. In addition, a significant difference observed between the mean scores of nurses and patients regarding patient-related, nurse-related, and environmental factors. Moreover, there are some barriers found during the communication process between nurses and patients, which can be mitigated by raising up the awareness of nurses and patients along with creating a desirable environment. Based on those results, the study recommended that nurses must be effectively trained in communication skills, in addition to be encouraged by constant monitoring of the obtained skills.

Throughout reviewing the previous literatures, it is obvious that most literatures focused on assessing and observing the communication process between healthcare providers and different cases of patients. In addition, the literatures focused on exploring the barriers that prevent the effective communication process. Most of literatures affirmed that there are 4 main barriers, which are: time constraints, workload, lack of awareness about health information by patients, and the lack of communication skills by healthcare providers. Moreover, a number of literatures used the qualitative approach by using content analysis and interviews, and other literatures used the questionnaires for both healthcare providers and patients.

In the current study, the descriptive analytical and quantitative approach is used, within a questionnaire that will be distributed among healthcare providers in Bethlehem district's hospitals. The similarities between the current study and previous studies are summarized in the approach used and tool of gathering the needed information from the healthcare providers, in addition to the subject of the study that intend to explore and identify the communication skills barriers between patients and healthcare providers.

Based on literature review, we constructed a conceptual framework for communication skills barriers between patients and healthcare providers, including four dependent variables (the time constrains, lack of medical and health knowledge by patients, lack of communication skills by healthcare providers with patients, healthcare providers workload). Those variable divided in three main categories that are: barriers related to healthcare providers, barriers related to patients, and environmental barriers. The current study will be an extension of these studies and its recommendations.

#### 4. Statement of the Problem

After reviewing the literatures related to the topic of the study, it has been found that the communication skills have vital importance in the healthcare sector, especially between the patients and healthcare providers. In addition, the study of communication skills barriers between healthcare providers and patients, considered one of the most important issues that increase the satisfaction of patients and providing high quality of healthcare outputs (Al-Kalaldeh *et al.*, 2020).

Furthermore, literatures have been conducted among hospitals at the international and regional levels, which indicates that there is a need toward conducting study at the local level in Palestine.

The gap that this study will try to fulfill represents in the vital need for studying the subject of communication skills barriers at the Palestinian hospitals. Therefore, the problem of the study represents in the following question:

**“What is the prevalence of the communication barriers between patients and healthcare providers at Bethlehem and Hebron health care centers from the perspectives of HealthCare Providers?”**

## 5. Significance

The scientific significance of this study represents in its results and methodology used, which can be a reference for the future researchers who might be interested in conducting researches related to the subject of this study, in order to build on its results. And being added value to the knowledge in the field of healthcare, according to the importance of communication skills at the healthcare sector. In addition to the importance of frequent reviewing of the barriers that hinder the communication between healthcare providers and patients, in order to provide high quality of healthcare and satisfying patients.

This study presents the most common barriers that hinder the communication process between patients and healthcare providers. Which might be a reference for decision makers into the hospitals at Bethlehem and Hebron districts, in order to develop policies and procedures that might contribute into decreasing the barriers of the communication process between patients and health care providers. In addition, this study presents results and recommendations that might be taken into consideration by management of hospitals and governmental bodies toward cooperation into designing a communication guidance toward the communication process between healthcare providers and patients.

## 6. Objectives

This study seeks to achieve the following objectives:

- 6.1 To assess the prevalence of communication barriers between patients and HealthCare Providers in Bethlehem and Hebron's healthcare centers.

6.2 To identify the types of communication barriers between patients and HealthCare Providers in Bethlehem and Hebron's healthcare centers.

6.3 To examine the differences in the prevalence of communication barriers between patients and HealthCare Providers at Bethlehem and Hebron's healthcare centers from the perspectives of HealthCare Providers due to age, gender, professional experience, qualification, work shift, division, profession, and authority.

## 7. Questions

This study seeks to answer the following questions:

7.1 What is the prevalence of communication barriers between patients and HealthCare Providers in Bethlehem and Hebron's healthcare centers?

7.2 What are the types of communication barriers between patients and HealthCare Providers in Bethlehem and Hebron's healthcare centers?

7.3 Are there any differences in the prevalence of communication barriers between patients and HealthCare Providers at Bethlehem and Hebron's healthcare centers from the perspectives of HealthCare Providers due to age, gender, professional experience, qualification, work shift, division, profession, and authority?

## 8. Hypotheses

Based on the study questions and objectives, the main hypotheses examined are:

8.1 There are no statistically significant differences at ( $\alpha \leq 0.05$ ) in the prevalence of the communication barriers between patients and HealthCare Providers at Bethlehem and Hebron's healthcare centers according to gender.

8.2 There are no statistically significant differences at ( $\alpha \leq 0.05$ ) in the prevalence of the communication barriers between patients and HealthCare Providers at Bethlehem and Hebron's healthcare centers according to qualification.

8.3 There are no statistically significant differences at ( $\alpha \leq 0.05$ ) in the prevalence of the communication barriers between patients and HealthCare Providers at Bethlehem and Hebron's healthcare centers according to work shift.

8.4 There are no statistically significant differences at ( $\alpha \leq 0.05$ ) in the prevalence of the communication barriers between patients and HealthCare Providers at Bethlehem and Hebron's healthcare centers according to division.

8.5 There are no statistically significant differences at ( $\alpha \leq 0.05$ ) in the prevalence of the communication barriers between patients and HealthCare Providers at Bethlehem and Hebron's healthcare centers according to profession.

8.6 There are no statistically significant differences at ( $\alpha \leq 0.05$ ) in the prevalence of the communication barriers between patients and HealthCare Providers at Bethlehem and Hebron's healthcare centers according to authority.

8.7 There is no statistically significant correlation at ( $\alpha \leq 0.05$ ) between the age and the communication barriers between patients and healthcare providers at Bethlehem and Hebron's healthcare centers.

8.8 There is no statistically significant correlation at ( $\alpha \leq 0.05$ ) between the professional experience and the communication barriers between patients and healthcare providers at Bethlehem and Hebron's healthcare centers.

## 9. Definition of Terms

**9.1 Communication Skills:** Fundamental clinical skills that if performed competently and efficiently, facilitates the establishment of a relationship of trust between the medical staff and the patient-customer, a truly therapeutic alliance (Chichirez & Purcărea, 2018).

**9.2 Communication Skills Barriers:** Set of practical and environmental factors that hindering the communication process between patients and healthcare providers.

**9.3 Patients:** Any person receiving medical attention, care or treatment. This person is often ill or injured and needs to be treated by a doctor or other medical professional.



**9.4 Healthcare Providers:** Efforts made to maintain or restore physical, mental, or emotional well-being especially by trained and licensed professionals, usually hyphenated when used attributively.

## 10. Limitations

This study conducted on the population of the HealthCare Providers at Bethlehem and Hebron health care centers, during the period of progressing this study 2022/2023.

## 11. Methodology And Design

### 11.1 Approach

The study uses a quantitative approach, using a questionnaire, which is appropriate to the exploratory nature of the research.

### 11.2 Population and Sampling

The target population consists of health care providers in Hebron and Bethlehem Governorates, in the West Bank during 2022, which includes 8968 persons; the population is comprised of 5403 males and 3565 females, as indicated in table no. 3.1 (Palestinian Central Bureau of Statistics, 2022).

Three hundred sixty-eight health care providers were stratifiedly selected, based on gender and Governorate. The sample population consists of health care providers working in Hebron and Bethlehem Governorates at the time of the survey. The sample size was calculated using the sampling web of <http://www.surveysystem.com/sscalc.htm>, sample size calculator, with a margin error of 0.05, as indicated in table no. 3.1, and appendix (B). The needed participations were selected randomly using the SPSS.

### 11.3 Instrumentation

The index of a 25-item scale was used to measure communication barriers between patients and HealthCare Providers as perceived by HealthCare Providers, that was developed by the research team, based on Norouzinia *et al.* (2016) scale, taking into consideration the cultural appropriateness in the Palestinian society. A 5-point Likert scale (ranging from strongly agree to strongly disagree) was used to measure responses. The survey was conducted through face-to-face interviews in

Hebron and Bethlehem Governorates, in the West Bank. The sampling survey instrument sought background information about participants' which included age, gender, professional experience, qualification, work shift, division, profession, and authority, as indicated in appendix (A).

### ***11.3.1 Instrument Validity***

Validation of the instrument proceeded in two distinct phases. The initial phase involved a group of referees and expert arbitrators, who provided some comments on the tool. The second phase involved the implementation of a pilot study (N=20) to validate the survey using exploratory factor analysis. Factor loading for all items exceeded 0.60 (0.61 to 0.79), which means that those items are suitable in measuring every item of communication barriers between patients and HealthCare Providers, as indicated in table no. 3.10.

### ***11.3.2 Instrument Reliability***

The reliability was tested using Cronbach's Alpha and Guttman Split-Half Coefficients to ascertain reliability and consistency of the survey. Cronbach's Alpha and Guttman Split-Half for the survey instrument was 0.82 and 0.80, respectively, indicating very good reliability and consistency, as indicated in table no. 3.11.

## **11.4 Sample Socio-demographic Characteristics**

The demographic breakdown of the participants was based on age, gender, professional experience, qualification, work shift, division, profession, and authority. In total, three hundred sixty-eight health care providers were conducted. Respondents were between 20 and 57 years of age (M 28.35, SD 6.53). Males represented 60.3% of the participants, while the remaining 39.7% were females; almost 85.1% of the participants were well-educated (Bachelor or above). Non-Governmental participants represented 63.6%, while the remaining 36.4% were governmental employees; the majority were nurses (78.8%); and their professional experience was between 1 and 30 years (M 6.07, SD 5.65). Nearly (55.7%) of the participants working in A shift, in difference divisions as follows, Medical (35.6%), ICU (25.3%), Surgical (19.8%), Emergency (10.9%), and Circulating (8.4%), as indicated in tables' no. 3.2-3.9.

## 11.5 Data Analysis

The questionnaire items were rated on a 1–5 Likert scale (1=Strongly Disagree to 5=Strongly Agree), the highest score indicates a high level of communication barriers between patients and HealthCare Providers. Descriptive statistics gauged prevalence of communication barriers among the sampled population using the following mean key (1-2.33=Low, 2.34-3.67=Moderate, 3.68-5=High). Additionally, the following statistical techniques were measured: Regression, T test, One-way analysis of variance, Tukey test, Cronbach's Alpha, Guttman Split-Half Coefficient and Factor Analysis using SPSS.

## 12. Findings

### 12.1 Prevalence of Communication Barriers Between Patients and HealthCare Providers

The mean score of communication barriers among HealthCare Providers as reported by the sample of three hundred sixty-eight participants was moderate (M 3.01, SD 0.46). More than half of the participants (60.2%) scored a moderate level of communication barriers with patients, as indicated in table no. 4.1.

### 12.2 Communication Barriers Between Patients and HealthCare Providers

Furthermore, findings revealed the communication barriers among HealthCare Providers ranked in a descending order as follows, “Differences in perceptions” (M 3.19, SD 1.09); “Emotional reactions” (M 3.18, SD 1.18). “Resistance to change” (M 3.16, SD 1.27); “Lack of feedback” (M 3.10, SD 1.13), and “Patient presents too many problems” (M 3.11, SD 1.06).

Furthermore, HealthCare Providers added the following as communication barriers with patients, that are, “Patient provides inconsistent information” (M 3.08, SD 1.08); “Patient's cultural beliefs about illness interfere with diagnosis and treatment” (M 3.09, SD 1.07), “Lack of knowledge of work operations” (M 3.07, SD 1.15); “Difficulty getting patient to understand diagnosis” (M 3.06, SD 1.12); and “Lack of credibility” (M 3.05, SD 1.04), as indicated in table no. 4.2.

## **12.3 Differences in Communication Barriers Prevalence Between Patients and HealthCare Providers according to the demographic breakdown**

Furthermore, the study explored the demographic breakdown over communication barriers prevalence between patients and HealthCare Providers with the aim of identifying any differences. Findings showed that gender, qualification and division do not show any significant differences, as indicated in tables' no. 4.3, 4.5-4.6, 4.10-4.11. However, it was found that authority, work shift, profession, age, and professional experience were significant variables, as indicated in tables' no. 4.4, 4.7-4.9, 4.12-4.15.

In relation to authority, the differences were in favor of the Governmental participants (M 3.17, SD 0.42), compared to (M 2.91, SD 0.46) for the No-Governmental participants: T-test value was (5.379,  $P=0.000$ ), as indicated in table no. 4.4. As for work shift, the differences favored participants in shift A (M 3.09, SD 0.45): F-value was (12.008,  $P=0.000$ ), as indicated in tables no. 4.7-4.9.

In terms of profession, the differences favored the doctors (M 3.32, SD 0.42): F-value was (20.309,  $P=0.000$ ), as indicated in tables no. 4.12-4.14.

Finally, findings indicated that there is a statistically significant positive correlation between the age and communication barriers prevalence between patients and HealthCare Providers, Beta-value was (0.336,  $P=0.001$ ), however, a statistically significant inverse correlation was found between professional experience and communication barriers prevalence between patients and HealthCare Providers, Beta-value was (-0.471,  $P=0.000$ ), as indicated in table no. 4.15.

## **13. Discussion And Recommendations**

According to the findings in the previous chapter, the study shows a moderate prevalence level of communication barriers between patients and healthcare providers. This means that the communication barriers occurred based on the work shift of healthcare providers, since there are high workload, insufficient time for doctors or nurses. And also it depends on the division of work for example the healthcare providers who work in the emergency department might have communication barriers with patients more than healthcare providers working in surgical division. This means that where ever there is a high workload in a division there will be a communication barriers caused by insufficient time, and mostly there is no opportunity for healthcare provider to

establish a healthcare relationship with the patient. This result is agreed with the study of Schallmo *et al.* (2019) that said that the workload of healthcare providers considered as communication barrier.

Moreover, findings revealed that the communication barriers among HealthCare Providers represents in the differences in perceptions, this is because the patient has less knowledge about his/her health status rather than the healthcare providers, in which the patient might expect his status but it is different in real from the perspective of healthcare provider. This support the findings of other communication barriers revealed in the study such as: the emotional reactions, resistance to change, lack of feedback, and Patient presents too many problems, due to the lack and insufficient communication with patients. Those results agreed with the results of Roodbeh *et al.* (2020), which affirmed that information delivering and the health information are communication barriers. In addition, this result agrees with the study of Al-Kalaldeh *et al.* (2020) who revealed the importance of psychological factors as communication barriers.

Furthermore, findings show that communication barriers with patients, provided by healthcare providers represent in that patient provides inconsistent information. This is because the patient frequently provides different status of his/her health status. In addition to patient's cultural beliefs about illness interfere with diagnosis and treatment, due to the cultural traditions into treating with male healthcare providers, so female patient might not provide the healthcare provider with her status, and might not allow the male healthcare provider to diagnose and treat her. This result agrees with the result of Shooten *et al.* (2020) study, which says that the cultural differences among patients lead to high level of communication barrier.

As well, findings showed that gender, qualification and division do not show any significant differences, this is because both females and males healthcare providers have the same duties and tasks, and facing the same barriers in each division, this result is adapted with the study of Fite *et al.* (2019). In addition, the qualification doesn't matter into the communication barriers, because the communication is a skill that learned by healthcare providers in the work. This result is adapted with the study of Kiani & Ahmadi (2019) which revealed that there is not significance of qualification level on the communication barriers.

While, the differences in authority variable were in favor of the Governmental participants compared to the Non-Governmental participants. This might be relating to that governmental hospitals have higher number of patients, which leads to higher workload for healthcare providers that cause the insufficient time, seeing number of patients in the same time, and then raising the level of communication barriers; this result is supported by the study of Sun & Rau (2017). As for work shift, the differences favored participants in shift A, when it is in the morning period, since the number of patients is more than other times, mentioning that the doctors' rounds held on the morning time, which need more time by healthcare providers.

Whereas, regarding the profession variable, the differences favored to the doctors, this is because the doctors are the first healthcare providers who communicate with patients.

However, findings indicated that there is a statistically significant positive correlation between the age and communication barriers prevalence between patients and HealthCare Providers. This is relating to the differences of age of healthcare providers might affect the level of communication barriers, for example the young healthcare providers might have less practical experience than the older healthcare providers, which makes the increasing of communication barriers level. This result is supported by the results of Fite *et al.* (2019) study. This support the result that revealed in the study of there is a statistically significant inverse correlation was found between professional experience and communication barriers prevalence between patients and HealthCare Providers.

Finally, the study's results also revealed that gender, qualification, and division do not indicate any significant differences over communication barriers prevalence between patients and HealthCare Providers. This indicates that the communication barriers prevalence between patients and HealthCare Providers are not very much influenced by these variables and are more likely to be affected by factors other than gender, qualification, and division.

Based on the previous discussion, it can be concluded that the communication barriers have high influence in the healthcare system, and they affect the quality of the healthcare. In which the communication barriers between patients and healthcare providers should be recognized by both parts of healthcare system, regarding the high satisfaction of patients and good work environment of the healthcare providers. Therefore, the study of communication barriers is important in the healthcare system. Accordingly, the research team recommends the following:

1. Providing training sessions for healthcare providers with different ages in communication skills, which will help into producing an effective communication with patients with different health status.
2. The ministry of health in Palestine should take into consideration the workload of the healthcare providers, by employing additional number of healthcare providers, which might decrease the workload of healthcare providers in the governmental hospitals.
3. The hospitals must provide a good work environment that affect the psychological factors influence the communication process positively.
4. The healthcare providers should be clear and obvious with the patients about their health status, which will help patients to understand exactly the status of their health, and facilitate the communication process.
5. There is a necessity for hospitals to increase the number of healthcare providers working in Shift A, where the highest workload occurs.
6. The need for future studies adopting the qualitative approach toward conducting in depth data gathering tools to assess the reasons beyond the communication barriers in healthcare sector.

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## 15. Appendixes

**Table no. (3.1). Distribution of the study population and sample by governorate and gender**

Governorate	Gender	Population	Sample
Bethlehem	Males	1540	63
	Females	1385	57
Hebron	Males	3863	159
	Females	2180	89
<b>Total</b>		8968	368

**Table no. (3.2). Sample distribution by gender**

Gender	N	Percent %
Male	222	60.3
Female	146	39.7
Total	368	100

**Table no. (3.3). Sample distribution by qualification**

Qualification	N	Percent %
Diploma or below	55	14.9
Bachelor	269	73.1
Master or above	44	12.0
Total	368	100

**Table no. (3.4). Sample distribution by work shift**

Work shift	N	Percent %
A	205	55.7
B	103	28.0
C	60	16.3
Total	368	100

**Table no. (3.5). Sample distribution by division**

Division	N	Percent %
Circulating	31	8.4
Medical	131	35.6
Surgical	73	19.8
ICU	93	25.3
Emergency	40	10.9
Total	368	100

**Table no. (3.6). Sample distribution by profession**

Profession	N	Percent %
Doctor	63	17.1
Nurse	290	78.8
Administrative	15	4.1
Total	368	100

**Table no. (3.7). Sample distribution by authority**

Authority	N	Percent %
Governmental	134	36.4
Non-Governmental	234	63.6
Total	368	100

**Table no. (3.8). Sample distribution by age**

Variable	N	Min.	Max.	Mean	Std. Deviation
Age	368	20	57	28.85	6.53

**Table no. (3.9). Sample distribution by professional experience**

Variable	N	Min.	Max.	Mean	Std. Deviation
Professional experience	368	1	30	6.07	5.65

**Table no. (3.10). Factor analysis of communication barriers scale between patients and HealthCare Providers**

No.	Items	Extraction
1.	Patient does not follow through with treatment or make lifestyle changes	0.69
2.	Insufficient time	0.61
3.	Difficulty getting patient to understand diagnosis	0.66
4.	Difficulty getting patient to understand implications of diagnosis	0.65
5.	Patient presents too many problems	0.63
6.	Patient history is rambling and disorganized	0.68
7.	Patient does not buy into treatment plan	0.67
8.	Patient provides inconsistent information	0.69
9.	Patient is uninterested in self-care or health maintenance	0.62
10.	Difficulty establishing rapport with patient	0.63
11.	Difficulty reconciling patient's self-diagnosis with physician's diagnosis	0.79
12.	Patient does not want to participate in a partnership with physician	0.69
13.	Patient's cultural beliefs about illness interfere with diagnosis and treatment	0.79
14.	Patient talks too much to interpreter	0.68
15.	Patient does not trust the healthcare provider	0.64
16.	Patient uses culturally based alternative therapies that the physician is unfamiliar with or disagrees with	0.69
17.	Patient stage of disease	0.66
18.	Lack of credibility	0.65
19.	Lack of feedback	0.63
20.	Emotional reactions	0.62
21.	Personality conflicts	0.68
22.	Lack of knowledge of work operations	0.64
23.	Differences in perceptions	0.69
24.	Physical noise and distractions	0.64

25.	Resistance to change	0.71
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**Table no. (3.11). Reliability of communication barriers scale between patients and HealthCare Providers**

Model	No. of items	Alpha
Cronbach's Alpha	25	0.82
Guttman Split-Half	25	0.80

**Table no. (4.1). Number, mean, standard deviation, and percentage of communication barriers prevalence between patients and HealthCare Providers**

Variable	N	Mean*	Std. Deviation	Percent %
Communication barriers total score	368	3.01	0.46	60.2

\*Mean out of 5 points.

**Table no. (4.2). Mean scores, standard deviation, and percentage for the communication barriers between patients and HealthCare Providers ranked in a descending order**

Communication barriers	Mean*	Std. Deviation	Percent %
Differences in perceptions	3.19	1.09	63.8
Emotional reactions	3.18	1.18	63.6
Resistance to change	3.16	1.27	63.2
Lack of feedback	3.10	1.13	62.0
Patient presents too many problems	3.11	1.06	62.2
Patient provides inconsistent information	3.08	1.08	61.6
Patient's cultural beliefs about illness interfere with diagnosis and treatment	3.09	1.07	61.8
Lack of knowledge of work operations	3.07	1.15	61.4
Difficulty getting patient to understand diagnosis	3.06	1.12	61.2
Lack of credibility	3.05	1.04	61.0

Patient talks too much to interpreter	3.04	1.14	60.8
Personality conflicts	3.03	1.15	60.6
Patient is uninterested in self-care or health maintenance	3.03	1.12	60.6
Patient stage of disease	3.02	1.08	60.4
Physical noise and distractions	3.00	1.14	60.0
Patient history is rambling and disorganized	2.98	1.07	59.6
Difficulty reconciling patient's self-diagnosis with physician's diagnosis	2.97	1.08	59.4
Insufficient time	2.96	1.06	59.2
Difficulty getting patient to understand implications of diagnosis	2.95	1.06	59.0
Patient uses culturally based alternative therapies that the physician is unfamiliar with or disagrees with	2.95	1.25	59.0
Patient does not trust the healthcare provider	2.93	1.17	58.6
Difficulty establishing rapport with patient	2.88	1.14	57.6
Patient does not want to participate in a partnership with physician	2.85	0.99	57.0
Patient does not follow through with treatment or make lifestyle changes	2.85	1.16	57.0
Patient does not buy into treatment plan	2.84	1.04	56.8
Total	3.01	0.46	60.2

**\*Mean out of 5 points.**

**Table no. (4.3). T-test for the differences in communication barriers prevalence between patients and HealthCare Providers according to gender**

Gender	N	Mean*	Std. Deviation	DF	T-value	Sig.
Male	222	3.01	3.00	366	-0.414	0.679
Female	146	3.01	3.02			
Total	368	3.01	0.46			



**\*Mean out of 5 points.**

**Table no. (4.4). T-test for the differences in communication barriers prevalence between patients and HealthCare Providers according to authority**

Authority	N	Mean*	Std. Deviation	DF	T-value	Sig.
Governmental	134	3.17	0.42	366	5.379	0.000
Non-Governmental	234	2.91	0.46			
Total	368	3.01	0.46			

**\*Mean out of 5 points.**

**Table no. (4.5). One-way analysis of variance for the differences in communication barriers prevalence between patients and HealthCare Providers according to qualification**

Source	DF	Sum of squares	Mean square	F-value	Sig.
Between groups	2	0.519	0.259	1.207	0.300
Within groups	365	78.400	0.215		
Total	367	78.919	-----		

**Table no. (4.6). Mean scores and standard deviation for the communication barriers prevalence between patients and HealthCare Providers according to qualification**

Qualification	N	Mean*	Std. Deviation
Diploma or below	55	2.92	0.49
Bachelor	269	3.02	0.46
Master or above	44	3.03	0.38
Total	368	3.01	0.46

**\*Mean out of 5 points.**

**Table no. (4.7). One-way analysis of variance for the differences in communication barriers prevalence between patients and HealthCare Providers according to work shift**

Source	DF	Sum of squares	Mean square	F-value	Sig.
Between groups	2	4.872	2.436	12.008	0.000
Within groups	365	74.047	0.203		
Total	367	78.919	-----		

**Table no. (4.8). Tukey test for the differences in communication barriers prevalence between patients and HealthCare Providers according to work shift**

Work shift	A	B	C
A		0.11582	0.31928*
B			0.20347*
C			

**Table no. (4.9). Mean scores and standard deviation for the communication barriers prevalence between patients and HealthCare Providers according to work shift**

Work shift	N	Mean*	Std. Deviation
A	205	3.09	0.45
B	103	2.98	0.40
C	60	2.77	0.50
Total	368	3.01	0.46

\*Mean out of 5 points.

**Table no. (4.10). One-way analysis of variance for the differences in communication barriers prevalence between patients and HealthCare Providers according to division**

Source	DF	Sum of squares	Mean square	F-value	Sig.
Between groups	4	1.594	0.398	1.871	0.115
Within groups	363	77.325	0.213		
Total	367	78.919	-----		

**Table no. (4.11). Mean scores and standard deviation for the communication barriers prevalence between patients and HealthCare Providers according to division**

Division	N	Mean*	Std. Deviation
Circulating	31	2.98	0.37
Medical	131	2.99	0.50
Surgical	73	3.12	0.52
ICU	93	3.02	0.40
Emergency	40	2.88	0.38
Total	368	3.01	0.46

\*Mean out of 5 points.

**Table no. (4.12). One-way analysis of variance for the differences in communication barriers prevalence between patients and HealthCare Providers according to profession**

Source	DF	Sum of squares	Mean square	F-value	Sig.
Between groups	2	7.903	3.951	20.309	0.000
Within groups	365	71.016	0.195		
Total	367	78.919	-----		

**Table no. (4.13). Tukey test for the differences in communication barriers prevalence between patients and HealthCare Providers according to profession**

Profession	Doctor	Nurse	Administrative
Doctor		0.38174*	0.15530
Nurse			-0.22644
Administrative			

**Table no. (4.14). Mean scores and standard deviation for the communication barriers prevalence between patients and HealthCare Providers according to profession**

Profession	N	Mean*	Std. Deviation
Doctor	63	3.32	0.42
Nurse	290	2.93	0.44

Administrative	15	3.16	0.32
Total	368	3.01	0.46

**\*Mean out of 5 points.**

**Table no. (4.15). Regression coefficients between age, professional experience and communication barriers prevalence between patients and HealthCare Providers**

Variables	N	Beta	Sig.
Age	368	0.336	0.001
Professional experience	368	-0.471	0.000

**R Square=0.059**

## CONFLICTS OF INTEREST

The authors declare no conflicts of interest regarding the publication of this paper.

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