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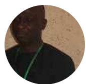

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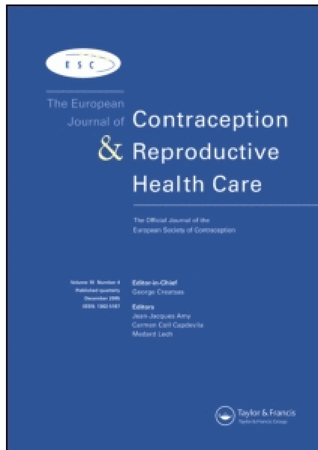

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Correlates of physicians' attitudes toward communication with HIV/AIDS patients in Ile-Ife, Nigeria

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ABSTRACT **Objectives** The study assessed physicians' perceptions of HIV/AIDS patients and identified the determinants of physicians' attitudes toward communication with HIV/AIDS patients in Ile-Ife, Nigeria.

Methods A semi-structured questionnaire was used to elicit information from 110 physicians in a cross-sectional survey, while in-depth interviews were conducted with 10 people living with HIV/AIDS (PLWHA) who had been previously admitted under the care of the physicians. Univariate, bivariate and multivariate analyzes were conducted.

Results Although most physicians perceived PLWHA positively and 58% of them displayed a positive attitude toward communication with PLWHA under their care, the expectations of the patients concerning HIV/AIDS communication were not being met. Only 43% of physicians expressed any degree of comfort engaging PLWHA in lengthy discussions or communicating the diagnosis of HIV to patients. The strongest correlates of physicians' positive attitude were previous exposure to HIV/AIDS counseling, the number of HIV/AIDS patients treated per month, the number of years spent in the care of PLWHA, and the gender of the physicians ($p < 0.05$).

Conclusions Physicians in Ile-Ife, Nigeria are not adequately equipped by way of training to effectively meet the expectations of their patients concerning HIV/AIDS communication. The large number of PLWHA in the country calls for urgent attention to address this important aspect of care.

KEY WORDS Physicians' attitudes, HIV/AIDS, Communication with people living with HIV/AIDS, Nigeria

INTRODUCTION

The HIV/AIDS burden in Nigeria has risen steadily from a seroprevalence rate of 1.8% in 1992 to 5.8% in 2001 and has then dropped slightly back to 5.0% in 2003[1]. The reality is that HIV/AIDS is now a major communicable disease in Nigeria, accounting for an increasing morbidity and mortality amongst all

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socio-economic groups. However, the disease is still shrouded in secrecy and a culture of silence at various levels in the country, especially in the family/household, the society and, sometimes, in the health facility and at the level of government. There is a social stigma attached to the disease[2,3] and families are reluctant to attribute any death in the family to HIV/AIDS for fear of isolation/ostracism. Studies outside Nigeria have shown that even among health care workers, people living with AIDS (PLHWA) were perceived differently from other people with fatal/terminal diseases and were more negatively evaluated compared with other patients[4]. Despite increased public and professional awareness, patients and physicians still tend to avoid discussion about HIV/AIDS[5].

Anecdotal information suggests that health care professionals in Nigeria may engage in discrimination against and stigmatisation of PLWHA[2,6]. The prevalence, character of and factors contributing to these practices are, however, largely undocumented[7]. UNAIDS had suggested that health workers' negative attitudes, their moralistic assumptions of guilt and the perceived incurability of HIV/AIDS may contribute to such responses, as all of these conspire to make it appear pointless to offer good-quality care to PLWHA[8]. A few scholars have even pointed out that PLWHA have difficulty complying with medical procedures in the hospital setting[9]. Could this be connected in any way with the mode of interaction and/or communication of the patients with the medical personnel, especially their physicians?

The manifestations of HIV/AIDS are varied and complex, involving virtually all systems and organs of the body. Hence, virtually every medical specialty now has a role to play in the successful management of HIV/AIDS patients, and physicians have to communicate with PLWHA, irrespective of their specialty of practice. Communication here is a social concept and it refers to 'the act of giving information' and 'the means of exchanging messages'. It will include physicians informing HIV/AIDS patients of their diagnoses; sharing correct information with patients regarding the seriousness or otherwise of their condition; updating patients at every opportunity of new developments in their management; discussing with patients issues of positive living with HIV/AIDS, prognosis, and for the terminally ill, end-of-life care; and giving patients the opportunity to discuss with their physicians, ask questions and seek clarifications. For example, internists and laboratory physicians often have to communicate the diagnosis and discuss positive living with HIV; oncologists, hematologists and internists have to communicate about adherence to anti-retroviral drugs and drugs for the treatment of opportunistic infections; and yet, others such as hematologists, surgeons, internists and interventional radiologists have to communicate about prognosis and end-of-life care.

The task of imparting information is neither straightforward nor easy. Not all patients have the intellectual preparation to understand the complexities of their illness or the emotional ability to deal with the threat to life that it may present. The physician must possess two separate skills: first to determine whether the patient can absorb the pertinent information, and secondly, to transmit the necessary facts in a sensitive, comprehensible manner. Several studies of communicating the diagnosis, for example, reveal that the physician's personal attributes often condition his or her activity[10]. Due to the paucity of information on the process of communication, information seeking and control in relation to HIV/AIDS patients and their physicians both globally and locally, we designed this study to assess physicians' perceptions of HIV/AIDS patients in Ile-Ife, Nigeria, identify the correlates of physicians' attitudes toward communication with HIV/AIDS patients and investigate HIV/AIDS patients' expectations concerning communication with their physicians.

RESEARCH METHODS

Background to the study

The study was carried out in Ile-Ife, a university town in Osun State, South-west Nigeria, between the months of June and September 2004 amongst specialist physicians. Ile-Ife, believed in history to be the ancestral home of the '*Yorubas*', a major Nigerian tribe, is served by a University Teaching Hospital, two secondary health facilities and several Primary Health Care facilities and private hospitals. Only the teaching hospital (the Obafemi Awolowo University Teaching Hospital, OAUTHC) is a referral center for the diagnosis and management of HIV/AIDS patients. Study participants were drawn from this institution.

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Research design

The study involved both quantitative and qualitative methodologies. The quantitative survey employed a descriptive cross-sectional design. Here, the exposure variables (socio-demographic characteristics, past experiences) and outcome characteristics (attitudes) of the respondents were assessed at the same point in time without any inbuilt directionality. The qualitative study involved in-depth interviews of people living with HIV/AIDS (PLWHA).

Sampling

The sampling frame for the quantitative survey consisted of all 210 physicians of various cadres—consultants and resident doctors employed at the OAUTHC, Ile-Ife. The inclusion criteria were being a physician of no less than the cadre of a senior resident and belonging to a clinical discipline that has direct contact with patients, especially HIV/AIDS patients. Inclusion was restricted to the ranks of consultants and senior residents because these are the officers who have responsibilities for final decisions on patient management and welfare. Based on these criteria, about 120 physicians were eligible to participate in the study. Verbal consent of all the eligible physicians was sought for participation. Eventually, questionnaires were distributed to all 120 of them, but only 110 of these returned their completed questionnaires even after 2 months of active retrieval of the instruments, representing a response rate of about 92%. For completeness and corroborative information, 10 patients living with HIV/AIDS who had been previously admitted on various wards in the OAUTHC in the 2 years preceding the survey (and sometimes, members of their families) were interviewed in their homes for them to express their expectations and experiences concerning communication with their physicians. These 10 respondents were met during a follow-up clinic in the hospital and were approached for possible participation in the study. They all consented to being interviewed in their homes by the principal investigator, himself a consultant and caregiver in the hospital, on a later date.

Data collection instruments

A self-administered semi-structured questionnaire was purpose designed and administered to all physician respondents by the investigators to elicit required information. This was pretested among 10 other physicians in the sampling frame, but who were otherwise excluded by the exclusion criteria before finalising the questionnaire. An in-depth interview guide was used to conduct interviews with the PLWHA and this included eight items that bordered on the patients' experiences and expectations. Each patient was interviewed at home to avoid the information bias that might be introduced by interviewing them within the hospital premises, especially in the presence of their physicians. All patients gave a verbal consent to participate; the research proposal and study instruments were approved by the Ethics committee of the teaching hospital.

Data analysis

Qualitative data generated were reported in descriptive terms through detailed content analysis of information obtained. Quantitative data generated were entered into a personal computer using the Epi Info Statistical Package version 6.4. This was exported into the Statistical Package for Social Sciences (SPSS) version 11 software after data cleaning for analysis. Results were presented using uni-, bi- and multivariate statistics. To determine the attitudinal score of each physician toward communication with PLWHA, weights (scores) were attached to the responses to questions that informed the respondent's attitude, on the basis of a score per positive response. Maximum score obtainable was 18 points. Attitudinal scores were summarised with descriptive statistics and the distribution was depicted graphically. Furthermore, any respondent that scored at least 9 points (50% of points obtainable and the median in the skewed distribution of scores) was categorised as having a positive attitude, while those that scored 8 points and below were classified as having a negative attitude toward HIV/AIDS communication. The relationship between the physicians' sociodemographic and other independent variables and their attitudes (dependent variable) were first tested in a bivariate model. The same variables were then placed in a multiple logistic regression model against positive attitude. Odds ratios and 95% confidence intervals were determined. Statistical significance of any observed association was accepted at significance (p-value) level of <0.05.

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The 10 consenting physicians who did not return their questionnaires were later visited to extract their sociodemographic characteristics. These were found to be comparable with those of the 110 respondents whose responses were analyzed for the study.

RESULTS

The age distribution of the physicians ranged between 29 and 63 years, with a mean age of 40.9 ± 7.2 years. Only one respondent was older than 60 years. Most (86%) were male and 92% were married, about half being married to spouses who are themselves doctors or nurses. Slightly more than two-thirds were of the consultant cadre, the rest being senior resident doctors. Forty-six per cent belonged to the medical specialties, 40% belonged to the surgical specialties, while the remaining 14% were laboratory physicians. Respondents had practised medicine for between 5 and 30 years, with a mean duration of practice of 15.4 ± 6.2 years. However, a majority (62%) had only practised their specialties for less than 10 years, with a mean duration of practice in the current specialty of 8.2 ± 6.3 years.

The physicians reported that they attended to between 1 and 25 PLWHA per month, with a mean of 4.5 and a median of two patients (results not shown). They have been involved in the care of PLWHA for a duration that ranged between 1 and 9 years, with a mean duration of 5.0 ± 2.4 years. However, only 20% reported ever having undergone any training in HIV/AIDS counseling, and just 43% of them expressed any degree of comfort with communicating the diagnosis of HIV to clients or engaging PLWHA in face-to-face discussions. The rest either felt uncomfortable or highly uncomfortable with communicating the diagnosis of HIV/holding discussions with PLWHA. Thirteen per cent of the physicians expressed dissatisfaction with their present knowledge base of the HIV/AIDS disease.

The foregoing, about communicating the diagnosis of HIV/AIDS, was buttressed by the report of the in-depth interviews held with PLWHA. In the words of one female patient who spoke in English:

> "*I went several times to clinic and ran a number of blood tests and other investigations. I was referred from clinic to clinic and from doctor to doctor before my diagnosis was eventually made known to me one clinic day after the fifth week of my referral to this hospital. I want to believe that all the previous doctors knew what was wrong with me from the results of my investigations but did not want to tell me, why I don't know.*"

In the words of another patient's relative who spoke in local language and is literally translated here:

> For the first week of my daughter's admission, we were never informed of her diagnosis. She herself was not well enough to ask questions. The health workers kept telling me and her siblings that they were waiting for her policeman husband who took a week to come around. It was a difficult time for all of us, and when the husband finally came, he told us in annoyance what diagnosis was conveyed to him, and has since left without coming back.

Seventy-six per cent of the physicians who responded to questions concerning the depth of interaction with PLWHA under their care reported that they would interact with the patients only on scheduled appointments, while only 15% of them would tolerate such interactions outside scheduled appointments (results not shown). Another 6.5% would avoid such interactions altogether. When further asked about the adequacy of the time they spend with PLWHA during every interactive process, 43% of the respondents reported that they would not describe the time they spend with the patients as adequate, compared with times spent with other patients who are not positive for HIV. The reasons given for this included 'competing demands on the physician's time by other patients and commitments'; 'being unsure of the nature of questions that PLWHA might ask during a long period of interaction'; and ironically, 'the fear of becoming infected'.

Again, referring to the findings of the in-depth interviews with PLWHA and their relatives, the consensus source of dissatisfaction with care in the hospital was the aspect of information sharing between the physicians and the patients. In the words of a middle-aged policeman who had been

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admitted on two previous occasions and spoke in English:

> "*During my first admission, other patients in my category and I were kept in the isolation ward where we were hardly visited by any of the health workers due to our HIV status. No one was there to allay our fears and anxieties, to tell us what the future holds for us no matter how bleak, and to empower us with the needed scientific facts for the progress or otherwise of our conditions. The only times we were visited was when the junior doctors came to collect blood. The situation however improved slightly by my second admission early this year; I was kept this time on the open ward and saw the workers a bit more frequently. However, the interaction and information sharing was still rather minimal.*"

In the words of a 25-year-old College of Education student that was referred from Ilesha who also spoke in English:

> "*I would have loved to be very acquainted with my doctors and other health workers during my period of hospitalisation. I tried asking so many questions about my conditions and the way forward for me, but I discovered that the doctors were always in a hurry the few times they came around. They spoke more to themselves and only wrote out an endless list of investigations to be carried out each time.*"

Further enquiries into the nature of the discussions that physicians engaged in with their patients revealed that only two-thirds of physicians discussed with them how to live positively with HIV. A similar proportion (65%) engaged their patients in discussions concerning the prognosis of their conditions, while only 28% of the physicians ever discussed issues of end-of-life care with those patients that were terminally ill. The reasons given by those who did not engage in discussions about 'positive living' and prognosis of HIV/AIDS with their patients included: 'a feeling of discomfort communicating disturbing information'; 'being uncomfortable facing up with the patient'; 'avoiding throwing the patient into misery'; and 'non-conviction of the efficacy of antiretroviral drugs'. Physicians who did not discuss end-of-life care with their terminally ill patients reported that they either never thought about that aspect of care, they were not comfortable taking up that responsibility and would rather leave that to the medical-social worker, or that they were also in denial of the possible fatal outcome of the disease process. Even among those respondents who reported to engage in end-of-life care discussions with their terminal patients, most felt that they were poorly equipped to do this.

When the PLWHA were asked about their expectations concerning HIV/AIDS communication with their physicians, the responses covered everything from options for cure and treatment, tips for positive living with HIV/AIDS, prognosis and end of life care in the terminally ill, side effects of drug therapy, options for gainful employment and continued marital sexual relationships. Many of these, the patients said, were however lacking in the care they receive presently from the health workers.

Further enquiries into the practices and perceptions of physicians towards the HIV/AIDS patients under their care revealed that, while as many as 80% signified their intention to continue to interact with PLWHA, sizeable proportions still perceived PLWHA negatively and would treat them accordingly (Table 1). About 29% of respondents would consider giving HIV/AIDS patients on admission an early discharge from the hospital for reasons that include 'protecting other hospital staff from risk of infection'. Ten per cent would give them a slow service because of a 'stigmatisation bias', while 8% reported that 'they perceive every PLWHA as one who works in the sex trade'. About 8% of respondents would also deny HIV/AIDS patients admission in the hospital for reasons that also include protecting the hospital staff from risk of contagion.

The distribution of the attitudinal scores of the physicians with regard to their communication with PLWHA is depicted in Figure 1. The scores ranged from 1 to 18 points with a mean of 10.13 ± 4.25. The distribution was skewed and multimodal; 12% of the physicians scored 8 points, 11% scored 7 points, while 9% scored 12 points. A summary of the attitudinal rating of the physicians revealed that 58% displayed a positive attitude toward communication with PLWHA under their care, while the attitude of the remaining 42% was negative. Table 2 depicts the summary of the bivariate relationships between identified variables of the physicians and their attitudinal ratings. The variables that were significantly

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Table 1 Perceptions and practices of physicians in Ile-Ife, Nigeria toward PLWHA

Respondents' perceptions/practices (n = 110)	*Yes*		*No*	
	Number	*%*	*Number*	*%*
It is my impression that every PLWHA works in the sex trade	9	8.0	101	92.0
I give slow service to PLWHA	11	10.0	99	90.0
I find excuses to deny HIV/AIDS patients admission	9	8.2	101	91.8
I give PLWHA relatively early discharge from the hospital	32	29.0	78	71.0
I would like to continue to interact with HIV/AIDS patients	88	80.0	22	20.0

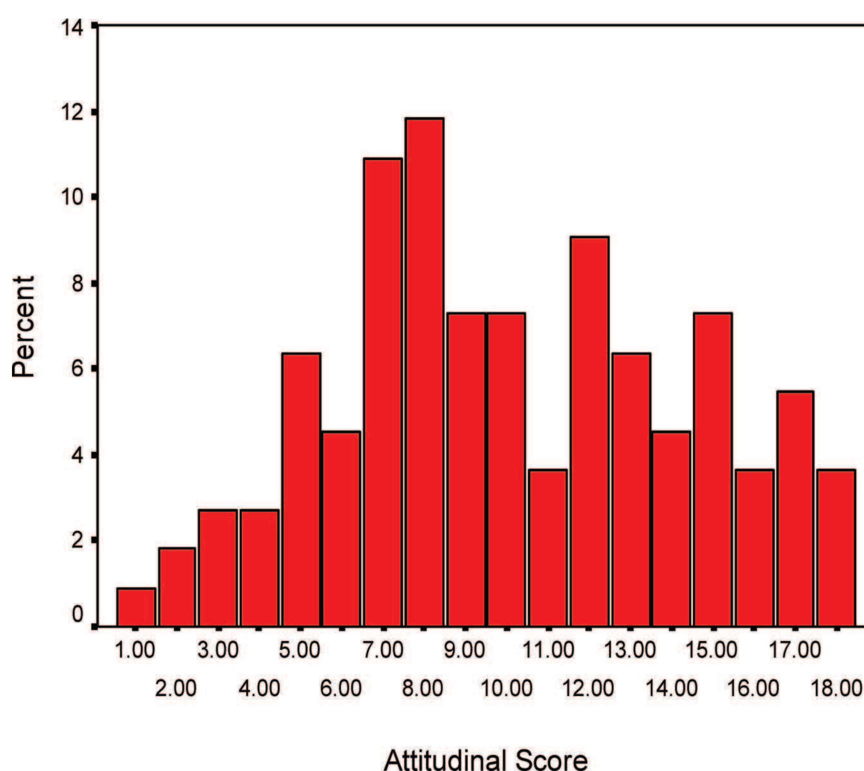

Figure 1 Percentage distribution of the attitudinal scores of physicians toward communication with PLWHA

related to the attitudes of the physicians toward communication with HIV/AIDS patients were the average number of HIV positive patients treated per month, the specialty of practice, respondents' duration of involvement in the care of PLWHA, previous exposure to training in HIV/AIDS counseling and the gender of the physicians. Respondents who were laboratory physicians (hematologists) were more positively disposed to communication with HIV/AIDS patients than physicians in other (medical and surgical) specialties ($p = 0.022$); female physicians were more likely to display a positive attitude toward communication with HIV/AIDS patients than their male counterparts ($p < 0.048$); physicians who treated five or more HIV/AIDS patients per month were more likely to have a positive attitude than those who treated less than five patients ($p < 0.016$); physicians who have been caring for PLWHA for more than 5 years were more likely to be positively disposed to HIV/AIDS communication than those who had

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Table 2 Summary of the bivariate analyzes between selected variables of physicians and their attitudes toward HIV/AIDS communication, Ile-Ife, Nigeria

Identified variables versus *attitudes*	X^2	*df*	*p-value*
Specialty of practice*	5.23	2	0.022
Age of respondents	0.170	1	0.680
Sex of respondents*	2.886	1	0.048
Marital status	1.225	2	0.542
Current professional status	0.738	1	0.390
Number of years in medical practice	0.325	1	0.568
Number of years in practice of current specialty	0.993	1	0.319
Number of HIV/AIDS patients attended/month*	5.750	1	0.016
Number of years in the care of HIV/AIDS*	4.273	1	0.039
Previous training in HIV/AIDS counseling*	3.987	1	0.046

*Variables that were significantly related to attitude.

been involved for less than 5 years ($p < 0.039$); and physicians who had been previously exposed to training on HIV/AIDS counseling displayed a more positive attitude toward communication with the patients than those without such training ($p < 0.046$).

Table 3 depicts the odds ratios of the physicians' variables in predicting a positive attitude toward HIV/AIDS communication with patients in a logistic regression analysis. The strongest correlate (predictor) of positive attitude was 'previous exposure to HIV/AIDS counseling'. The other significant correlates of positive attitude were 'the gender of the physicians', 'the number of HIV/AIDS patients treated per month' and 'the number of years spent in the care of HIV/AIDS patients'. For all four variables, the relationships were as described in the bivariate analyzes above.

Table 3 Adjusted Odds Ratios (and 95% confidence intervals) from logistic regression analyzes assessing the association between positive attitude toward communication with PLWHA and selected variables of physicians, Nigeria

Variable	*Odds Ratio (95% CI) (n = 110)*
Sex	
Male(*ref*)	1.00
Female	1.79 (1.26–2.54)*
Marital status	
Single (*ref*)	1.00
Married	1.31 (0.85–1.99)
Separated/divorced	2.50 (0.77–6.55)
Specialty of practice	
Surgical (*ref*)	1.00
Laboratory medicine	1.33 (0.72–2.55)
Other medical	1.32 (0.56–2.97)
Years of medical practice	
<10 years (*ref*)	1.00
≥10 years	0.94 (0.63–1.37)
Years spent in current specialty	
<10 years (*ref*)	1.00
≥10 years	0.90 (0.46–1.75)
Current professional status	
Senior resident (*ref*)	1.00
Consultant	1.10 (0.67–1.82)
Number of HIV/AIDS patients attended per month	
<5 (*ref*)	1.00
≥5	1.94 (1.05–3.65)*
Duration of involvement in care of HIV/AIDS patients*	
<5 years (*ref*)	1.00
≥5 years	1.56 (1.20–2.09)*
Previous training in HIV/AIDS counseling*	
No (*ref*)	1.00
Yes	2.28 (1.05–4.20)*

CI = confidence interval; *ref* = reference group.
*Significantly different from the reference group at $p < 0.05$.

DISCUSSION

Both AIDS and HIV infection are widely viewed as incurable and progressive, and as posing a risk to others through transmission (high peril). Clearly, the discriminatory popular attitude is layered upon a pre-existing stigma and, to some extent, is equated with it. Reactions to AIDS patients may be in part reactions to gay men, drug users, sex workers or 'outsiders' in general[11]. Health workers are, however, not left out in the metaphors that constitute a series of 'ready-made' but highly inaccurate explanations that provide a powerful basis for both stigmatisation and the discriminatory responses. Despite expressing satisfaction with their knowledge base of the HIV/AIDS

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infection, and a fairly long duration of care for PLWHA, less than half of the physicians in this study still expressed any degree of comfort communicating the diagnosis of HIV/AIDS to patients or holding lengthy discussions with PLWHA. A sizeable proportion of physicians would not even interact with HIV/AIDS patients outside scheduled appointments. Reis *et al.*[7] have reported similar and other discriminatory attitudes and practices of health workers toward PLWHA in Nigeria. The PLWHA interviewed in-depth also corroborated this finding, as they cited their past experiences under the care of the physicians.

Epstein *et al.*[5] recognised that, despite increased public and professional awareness, physicians still tend to avoid discussions about HIV/AIDS with patients. They identified the lack of a good opening line, an inappropriate context of speech, and vague language as attributes of poor interactions between the physicians and HIV/AIDS patients. While the physicians in the present study advanced various reasons for their actions, the study findings might not be unconnected with the fact that the majority (80%) of the physicians have never been trained on any aspect of HIV/AIDS counseling in the past. Furthermore, their basic medical training curriculum did not emphasise the requirements for such roles. However, while HIV/AIDS is still incurable today, it usually runs a chronic course and could affect several organ systems of the body, thus requiring the expert advice of a diversity of medical specialists. All these would require training in HIV/AIDS counseling to function effectively in their roles in HIV/AIDS management.

One of the reasons given by the physicians for not spending enough time with HIV/AIDS patients during periods of interaction was the fear of becoming infected. It is ironical that people who know the cause and modes of transmission of HIV infection should express such irrational fears about contracting the disease during a casual contact. However, other authors like Reis *et al.*[7], and Aggleton and Homans[12] have acknowledged the fact that factual information is not, of itself, sufficient to allay irrational fear about HIV/AIDS transmission. They reported that many still believe that AIDS spreads like miasma through the air, and such beliefs have been found to co-exist with mainstream bio-medical understanding of HIV/AIDS transmission, even among health care professionals. An additional element that has been identified for such behavior is the fear of being 'innocently' infected through worker-related exposure and then being subsequently accused of behaving in some 'forbidden manner'. Other reasons given by the physicians for their lesser availability included 'competing demands on their time by other patients and commitments' and 'being scared of the nature of questions that PLWHA might ask during a long period of interaction'.

Other physicians were also found to exhibit such discriminatory practices as denying HIV/AIDS patients admission and giving them an early discharge from the hospital. While the reasons advanced for such practices included wanting to protect the hospital staff and, possibly, other patients from the risk of infection, the physicians' actions might not be unconnected with the helpless circumstances in which they worked. During the lifespan of this study, the availability of antiretroviral drugs for the treatment of PLWHA was very limited in Ile-Ife and, when available, the drugs were very expensive. Physicians were quite handicapped about the treatment options they could offer PLWHA and, therefore, sometimes resorted to referrals. Wanting to protect the HIV/AIDS patients from contracting potentially lethal infections would have, however, been a remote reason for the physician's actions. This is because these physicians, who were in the minority, tended to be discriminatory in their attitudes rather than protective of PLWHA. Furthermore, another previous study of health workers' attitudes and practices toward HIV/AIDS patients in Nigeria[7] did not report health workers expressing such 'protective' concerns about the patients they treated.

While the physicians who exhibited negative attitudes toward HIV/AIDS patients were in the minority in this study, it was difficult to compare the attitudes of the physicians with those of other hospital staff such as social workers, nurses and midwives. This is because these other categories of staff were not evaluated in this study and the only other study of Nigerian health workers' attitudes and practices toward PLWHA found in literature[7] neither compared attitudes and practices between professionals, nor explored associations between professional characteristics and different outcomes. Any comparisons of attitudes and practices among the different health

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professionals may, therefore, only be speculative, and would need further evaluation in a subsequent study.

Although HIV/AIDS patients in this study desired that their physicians discuss everything concerning their care with them, only about two-thirds of the physicians ever engaged their patients in discussions about positive living and prognosis. A far smaller proportion engaged the patients in discussions about end-of-life care for the terminally ill. The findings were consistent with those of other authors like Curtis and Patrick[13], Jackson *et al.*[14], and Deale and Wessely[15], concerning the patients' view of medical care and information sharing with their physicians. The findings were also similar to those of Curtis *et al.*[16], that physician barriers are more strongly associated with fewer end-of-life communication than patient's barriers. The most probable explanation for these findings, as some of the physicians have willingly expressed, is that the physicians are poorly equipped (due to gaps in their training) for these roles of communicating especially disturbing information, and many feel unsure and uncomfortable engaging in such discussions with their patients. Some physicians, while trying to conceal their inadequacies, even hide under the arguments that discussing end-of-life care with patients could cause more harm, and even hasten death[13]. Unfortunately, an important area of counseling that never got mentioned either by the physicians or their patients was 'risk reduction' on the parts of both patients and their contacts. This has implications for the continued spread of the infection in the community.

In this study, care for PLWHA and training in HIV counseling translated into a positive attitude toward HIV/AIDS communication more than the chronological age of the respondents, their years of experience in the general practice of medicine or even their professional status. In fact, the number of years in the general practice of medicine, which could also be a surrogate for age and probably professional status of the respondents, was inversely related to positive attitude of respondents toward communication with HIV/AIDS patients. This meant that less experienced and probably younger and more junior physicians may feel more comfortable about HIV/AIDS communication because their training has exposed them to more 'modern' notions about openness with patients. Alternatively, younger physicians may treat younger patients, who expect their doctors to be more open. Physicians who treat many HIV/AIDS patients may feel more positively about HIV communication for several reasons. They may, for example, have the closest acquaintance with the needs of PLWHA, be most accustomed to communicating disturbing facts, or treat patients who have lived with HIV/AIDS for sometime and adjusted emotionally to their illnesses. The effects of average duration of involvement in the care of HIV/AIDS and previous exposure to training in HIV/AIDS counseling underscore the importance of acquiring the necessary skills in order to render effective and efficient services to PLWHA, a condition in which communication is probably the best form of treatment available to many nowadays.

CONCLUSION

Most physicians in Ile-Ife perceive PLWHA positively and display a positive attitude toward communication with these patients. However, they are neither comfortable with HIV/AIDS communication nor are they meeting the information needs of their patients, which span a wide spectrum, revealing major deficiencies in the interpersonal communication and counseling skills of the physicians. Because the doctor's role, in addition to treating the disease, now largely includes assisting in the management of and adjustment to the problems that disease creates, there is an urgent need to review the training curriculum of physicians in Nigeria at both undergraduate and post-qualification levels. This curriculum review should better emphasise relevant and time appropriate (e.g. final year) instructions in Health Sociology and Health Communication & Counseling. Furthermore, it should build competencies in communicating how patients can better live with chronic communicable (e.g. HIV/AIDS) and non-communicable diseases generally, as many patients suffering from these conditions not only currently take up a lot of hospital beds, but also a lot of medical personnel man-hours. For practising physicians, this might take the form of short courses and medical updates. Credits earned from such updates may be made a prerequisite for renewal of licenses to practise at specified intervals.

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REFERENCES

1. Federal Ministry of Health (FMOH). *Report of the National Action Committee on AIDS*. Abuja: FMOH 2003.
2. Alubo O, Zwandor A, Jolayemi T, *et al*. Acceptance and stigmatization of PLWA in Nigeria. *AIDS Care* 2002; 14:117–26.
3. Centre for the Right to Health. *Human rights and HIV/AIDS: experiences of people living with HIV/AIDS in Nigeria*. Lagos: Centre for the Right to Health 2001. Available at: http://www.crhonline.org/pubdetail.php?pubid=2.
4. Panebianco S, Uribe P, Del Rio C, *et al*. Human rights violations and AIDS, two parallel public health epidemics [abstract]. 10th International Conference on AIDS and STDs, Yokohama, Japan, 7–12 August 1994.
5. Epstein RM, Frarey L, Beckman HB. Talking about AIDS. *AIDS Patient Care STDS* 1999;13:545–53.
6. Adelekan ML, Jolayemi SO, Ndom RJE, *et al*. Caring for people with AIDS in a Nigerian teaching hospital: staff attitudes and knowledge. *AIDS Care* 1995;7(Suppl 1): S63–72.
7. Reis C, Heisler M, Amowitz LL, *et al*. Discriminatory attitudes and practices by health workers toward patients with HIV/AIDS in Nigeria. *PLoS Med* 2005;2:e246.
8. United Nations Joint Programme on HIV/AIDS (UNAIDS). *Reports on the global HIV/AIDS epidemic*. Geneva: UNAIDS 2000.
9. Blumenfield M, Milazzo J, Wormser G. Non compliance in hospitalized patients with AIDS. *Gen Hosp Psychiat* 1990;12:166–9.
10. Chesney MA, Smith AW. Critical delays in HIV testing and care—the potential role of stigma. *Am Behav Sci* 1999;42(7):1162–74.
11. Pollak M, Paicheler G, Pierret J. *AIDS, a problem for sociological research*. London: Sage Publications 1992.
12. Aggleton P, Homans H. Training the AIDS educator. *Nursing Times* 1987;83:40–4.
13. Curtis JR, Patrick DL. Barriers to communication about end-of-life care in AIDS patients. *J Gen Intern Med* 1997; 12(12):736–41.
14. Jackson JL, Chamberlin J, Kroenke K. Predictors of patient satisfaction. *Soc Sci Med* 2001;49:651–61.
15. Deale A, Wessely S. Patients' perceptions of medical care in chronic fatigue syndrome. *Soc Sci Med* 2001;52: 1859–64.
16. Curtis JR, Patrick DL, Caldwell ES, *et al*. Why don't patients and physicians talk about end-of-life care? Barriers to communication for patients with Acquired Immunodeficiency Syndrome and their primary care clinicians. *Arch Intern Med* 2000;160:1565–6.