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Patient-Provider Encounter: The Contemporary Cameroonian Story

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by

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DEDICATION

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ABSTRACT

Most communication scholars recognize that cultural beliefs influence health and interactions about health. Within the African context, religious cultural beliefs constitute dynamic elements of the culture. My dissertation explains the influences of religion and culture on patient-provider interactions in Cameroon. My field research sought answers to the following questions: How do the assumptions of the Western medical model intersect with those of the native culture in patient-provider interactions? How do Cameroonian providers and patients conceptualize health and illness? How does Cameroonian culture, especially native and Christian religious beliefs influence the beliefs and practices of providers and patients? How do interactions between providers and patients incorporate narrative and dialogue? How do providers and patients perceive the quality and ethics of health related interactions?

I used participant observation and field interviews in urban and rural areas in Cameroon as the context for my collection of data. When conducting interviews, I asked questions pertaining to health beliefs and health interactions that produced lengthy narrative responses from providers and patients in Cameroon. My analysis of the 22 transcribed interviews utilized

thematic analysis. The data analysis yielded the following results. Cameroonian patient and provider participants used the Western medical model along will other native cultural approaches to health to construct their health beliefs. In ways that differ from other research studies on health beliefs, Cameroonians conceptualize health as physiological, moral, emotional, spiritual and financial. Cameroonians' native cultural beliefs in God, prayer, fear of death and spiritual interventions influence the kind of values that they hold and when they are involved in patient-provider interactions. Cameroonians' values related to community, family, and love as well as their expectations about humanistic care revealed the importance of humility, compassion and gratefulness to the quality of health care. Specifically, my research in Cameroon showed that both providers and patients equate the quality of health care with the quality of patient-provider interactions. My data analysis demonstrates the importance of specific communication behaviors to patient-provider interaction. These communication behaviors centered on expressions of responsibility, listening, time for the other, and treating others as family. These communication behaviors share many features of dialogue and narrative medicine that scholars in the U.S. recommend for quality interactions. Finally, my research identified differences between providers and patients in their perceptions of waiting time and rule following. The patients' responses about reasons for waiting and the perceived length of the waiting time cast a negative light on the providers. Moreover patients' resistance to some of the rules given by providers showed that patients' believe that rules impede the quality of the health care they receive. This dissertation study is an innovative attempt to analyze how culture and native and Christian religious beliefs influence the content and the quality of patient-provider interactions in urban and rural setting in Cameroon. My study shows that traditional cultural beliefs about health and healing continue to influence health interactions. Specifically, the beliefs and practices of

providers and patients utilized a mixture of Native religion, Christianity, and the western and scientific model of diagnosis and treatment of patients. The convergence of these different beliefs strongly influences the content and quality of communication in patient-provider interactions.

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“There is one who speaks like the piercings of a sword,

But the tongue of the wise promotes health.”

Proverbs 12:18

CHAPTER 1:

INTRODUCTION

Suffering and the absence of pain are experiences that most if not every human being can understand yet few can claim to enjoy. In some contexts such as Cameroon, Africa, suffering and the need to be protected from the pain of an incurable illness or the loss of a loved one are experiences that lead some to believe that they are in need of well-being. But how can one seek something that he or she lacks the adequate words to describe?

Research Perspective

Health, that is the individual's state of well-being, is one of the most critical and basic needs, since it is intrinsically tied to life itself. In my view the notion of health expands from an individual's physical, emotional, psychosocial, and spiritual well being to include even the prosperity of one's material possessions (Mbiti, 1970). While a narrow definition of health might be problematic in the Western world, the same definition is fundamental within the African traditional context. In traditional Africa, health existed in conjunction with multiple aspects of life, essentially religion. The religious life of traditional Africans included various rituals and beliefs around the notion of spirituality and worship. Spiritual manifestations and activities were used in order to explain good and ill health as well as to restore health (Mbiti, 1970). During the colonial period, new religious beliefs from Christianity were introduced to the pre-existing African traditional way of life. While Christianity was introduced by Westerners from the British and French colonial powers, some of the beliefs and stories related to Christianity were familiar to followers of African traditional religion. Connections between Christianity and Native religions can be traced back to the times of the Egyptian empire and the presence of Jewish slaves in Africa. Some of the Old Testament biblical laws that were practiced by Jews and some

of the local Africans can still be observed in contemporary practices of African religious. However, with the coming of the New Testament and the life of Christ, Christianity brought the notion of grace, which stands in opposition with the philosophical approach of spiritual African traditions. The intrinsic connections existing between religio-spirituality and health in traditional Africa raise questions in regards to differences between Native religious practices, which focus on punishment, and Christianity, which focuses on love (Kierkegaard, 1995). Thus, the introduction of Christianity as a new belief system brought some new expectations, approaches or practices to the notion of health care.

Since Christianity is a relatively new religious belief system, its introduction created conflict and an inner struggle for Cameroonians seeking to understand their health and its connections to religion. As a Cameroonian born after colonial times, I have witnessed other Cameroonians attempt to connect Western health care and traditional health care administered by believers of Native religions. I clearly remember the story of a lady who worked as a nanny for our family and who developed a fibrosis. She consulted both a traditional healer and a western health provider. The traditional healer suggested that she was the victim of a curse, while the western health provider suggested the need for a surgical operation. The lady was a Catholic Christian, and I believe she had asked for prayer concerning her ailment. A few years after a weakening battle against the illness, going back and forth from traditional healers to western health providers, struggling to decide which of the two diagnoses was the answer to her ailment, the lady wasted time and her illness further developed. She finally passed away. The news was devastating to our family. However, the question remained: What was the nature of the communication between the lady and her health care provider? During their interactions, which stories were told and which ones were left out? Which stories were validated and was there really

any dialogue? Such ambiguous events are common in Sub-Saharan Africa. Contemporary tales of ill health related to spiritual activity and limited communication and understanding of western trained health providers populate Cameroonian conversations in various social spheres.

Besides, the apparent polarity between the traditional health approach and the western health approach, the communication between health providers and patients is made more complex because of the financial strain experienced by health providers and their Cameroonian patients. Reports (Fongwa, 2002) show that doctors who work in rural settings in Cameroon tend to be frustrated because they cannot engage in secondary remunerative activities in order to satisfy their financial needs in the same way as providers who work in the city do. The dissatisfaction of health providers in rural areas is a threat to healthy encounters with patients in those locations.

The number of doctors who are willing to work in rural areas is so low that access to care is unfortunately scarce (Fongwa, 2001). Therefore, even when the patient-provider encounter is not threatened by providers' dissatisfaction, the high amount of patients per doctor jeopardizes the level of personal investment that doctors can provide to patients. For doctors practicing in the urban settings, the low remuneration of doctors working for the government and the high and constant demands for health care services likely affect doctors' motivation to invest in their patients or engage in any substantial dialogue with them. Dialogue occurs when each individual makes room for the other, fully listening by suspending judgment while receiving the other and seeking to meet their needs through the presence of the "in between" (Buber, 1966). The state of the Cameroonian western adopted health care seems to reside in a limited space that restricts the quality of the patient-provider encounter.

Research Goal

Research shows that the African traditional way of life is constantly in the process of change depending on the realities faced by local community members (Mbiti, 1970). Therefore, the socio-religious changes that occurred as a result of colonization likely caused some changes in the African traditional approaches to physical, social and spiritual life. While these changes can be observed in Cameroonians' overall conceptualization of health, an exploration of the influence of Christianity on the interaction between the health provider and the patients in light of the co-existing Native and Christian beliefs within a precarious health care system are of interest. Thus the goal of this study is to examine health beliefs and interactions in order to explain the ways in which Native religions and Christianity contribute to patient-provider interactions within the Cameroonian context.

Specifically, I explore the cultural context in Cameroon and how it influences health, how providers and patients conceptualize health beliefs, how providers and patients perceive interactions with one another, and identify the kinds of communication practices that impede and enable effective patient-provider interaction.

Within the Cameroonian cultural context, stories and narratives are familiar ways to create and maintain religious and health beliefs. Research on the narrative paradigm suggests that humans are inherent homo narrans (Fisher, 1984), capable of telling stories. Cameroonians have used stories not only for the purpose of entertainment but also for the maintenance of customs and traditions. Because the use of narratives is such an integral part of Cameroonians' oral culture, it is reasonable to expect that Cameroonians' interviews will be told in story form. The stories are usually consistent with other stories produced in the same cultural context, and they hold enough coherence to make sense to listeners. Such findings are readily applicable to the

sub-Saharan African context where stories were used traditionally in order to keep social harmony and preserve spiritual, social and physical health.

I conducted this study within the Cameroonian context. First, I took field notes while observing health care processes, such as patient-provider interactions taking place in urban and rural clinics. Secondly, I conducted in depth interviews with patients and doctors focusing on accounts and recounts of patient-provider encounters, as well as conceptualizations of health, specifically the meanings attributed to healing.

Assumptions

My research is developed under specific assumptions; the first is the importance of understanding interaction in order to comprehend stability and change in the individual and society (Blumer, 2004). During the communication process, individuals redefine themselves as well as their actions, and their new definitions impact society. Stories are told and repeated in interactions that constitute opportunities for individuals to define and redefine their roles. Therefore, stories function as information to establish cultural norms, as agents of change in interactions, and as part of complex recreated social narratives.

Another assumption is the importance of narratives in human interaction. Humans interpret and direct the social situation (Blumer, 2004). Thus in interactions individuals create messages and make sense of messages using their understanding of the world based on acquired knowledge and cultural beliefs. Human cognitive schemas that make sense of interactions are a product of culture, and the encoding and decoding of messages generally takes place within the parameters of these cognitive schemas. The cognitive schemas are congruent with the broad social narratives inherited from the tradition and reproduced in the local cultural context.

In his development of the narrative paradigm, Fisher (1984) notes that humans are homo narrans who all have the ability to tell stories, and human accounts constitute critical artifacts in the understanding of individuals' sense making. Humans also have the innate ability to evaluate good from bad stories, by looking at whether or not their elements are internally coherent and whether they make sense with the rest of the stories that make up the grand social narrative. Thus, stories are communicative artifacts that are accessible to all interactants in a culture, can be evaluated by all of them, and reflect their sense making of the world. Therefore, stories are value-laden because they embed the values of the one telling the story. Thus using this kind of dialogical process individuals share stories which reflect their personal realities.

The final assumption is the key role of selflessness for determining ethical and effective interactions in patient-provider dialogue. Dialogue is an encounter that is characterized by the priority of the other over self so that one primarily seeks to listen (Lipari, 2004) and respond (Levinas, 1996) to the other before tending to one's own existence. Therefore the use of narratives for the purpose of sense making and cultural interpretation becomes a means of entering into dialogue only if the individuals who are part of the interaction approach the encounter selflessly.

Justification and Problem Statement

The problem in Cameroonian health care today is that it fails to consider how religious beliefs affect medical practices. Sub-Saharan African societies are spiritual and communal. The individual belongs to a greater social network. Therefore the health of a member of the group is closely tied to the nature and the development of the individual's relationship with other community members. Connections of the individual to the rest of the community exist both in the physical and the spirit world (Mbiti, 1991). The adopted biomedical health care model

currently practiced in Cameroon fails to acknowledge the traditional nature of Sub-Saharan societies such as Cameroon. The dismissal of the African traditional approach to life is an important challenge, which is added to an already strenuous system, complicating the relationship between providers and patients. Assessing the health needs of Cameroonians within the context of the patient-provider encounter, while acknowledging the traditional connection between religion and health, likely will make way for healthier provider and patient encounters.

Current State of Patient-Provider Relationships

The current state of patient-provider relationships in Cameroon is unhealthy. Providers often come into the encounters resentful and unsatisfied with the economic state of the health care system. Despite the shortage of doctors in Cameroon, one doctor for more than 10,000 patients (Einterz, 2001; Fongwa, 2002), the working doctors receive unsatisfactory remunerations (Fongwa, 2002). Besides the lack of adequate incentives, most doctors working in public hospitals are trained in Western medicine where they are taught to rely on a purely biomedical model. During the encounters, the health providers are mainly concerned with the patient's physiological state, rather than the full social and spiritual self of the patient. Therefore, not only are providers unmotivated in meeting their patients, but they also tend to relate with their patients as mere bodies in need of diagnosis (Charon,2009), instead of as whole selves who have dysfunctional bodies.

While Cameroon is not the only country suffering from deficient patient-provider encounters, it is by far one of the poorest countries facing this issue. Yaounde Central hospital, which is one of the main public hospitals in the political capital, has limited infrastructures to tend to the increasing number of low income patients residing in Yaounde. Family members witness their loved ones die from illness, such as diabetes, simply because health providers failed

to carefully handle and keep track of the patients' health records (Dehayem et al., 2008). The waiting areas of urban hospitals are populated with patients in dire need of help, waiting for a doctor's appointment. Some of the patients have traveled for hundreds of miles in very critical condition because the urban hospitals are the only ones with specialized equipment (Fongwa, 2002). Just as doctors are, the rest of the health care personnel are underpaid. The economical strain experienced by health care personnel likely is connected to the feeling of abandonment experienced by some patients (Hell & Hell, 2011). Needless to say the events leading up to the patient-provider interaction do not lay the foundation for an effective dialogic encounter.

Encounters with traditional healers are generally less strenuous than with Western mainstream doctors. Traditional healers are directly remunerated by their patients as part of the private sector. However, the relationships between healers and their patients remain quite hierarchical. The healer provides the diagnosis, and in general the competence of the healer is measured by his or her ability to spiritually assess the ailment of the patients without any help from them. Therefore, even in the traditional context, the health care encounter remains unidirectional (Rosny, 1985). Despite the holistic approach of the traditional healer who tends to the patient's emotional, physical, social and spiritual needs, the communication between the healer and the patient rarely takes place in ethical dialogue.

The unidirectional nature of patient-provider interaction within the Cameroonian health care system could constitute a threat to the patient's health, especially for illiterate patients (Fongwa, 2002). Reports from the CIA worldfact book (US Central Intelligence, 2011) show that about 64 percent of the Cameroonian population is literate; this leaves nearly 40 percent of Cameroonians who are unable to read and write. Unidirectional patient-provider interactions in which patients are not given enough time to comfortably communicate, limit these patients'

opportunity to fully comprehend and process information by means of questions, clarifications, elaborations and/or applications of new information.

Finally, like other Sub-Saharan countries, Cameroon retains various aspects of its traditions. Traditional values such as community, religiosity, and respect of tribal rituals remain strong (Mbiti, 1970). Unlike Eastern Africa or South Africa, where the practice of African traditional beliefs is relatively optional, in several parts of Cameroon the traditional approach to life remains primary. Therefore, encounters with health providers within the adopted western health care context are often complementary, or secondary, to traditional beliefs about the patients' ailments (Fongwa, 2002; Makhulu, 2001; Mbiti, 1991). The conflict between the revered place of cultural beliefs held by patients and the western paradigm enacted by health providers within Cameroonian hospitals further complicates the communication between providers and patients because providers look at patients as irrational and stubborn, while patients are left in desperate fear for their lives.

Healthy patient-provider encounters would facilitate health providers' tasks in diagnosing the patients' illness and also better address the patients' health communication needs. The provision of health care through "unhealthy" communicative exchanges can be the major obstacle to patients' access to care. The present study seeks to investigate and understand Cameroonians' health beliefs and practices and decipher the current understanding of providers and patients regarding the quality of their interactions.

Research Questions

Within the context of communication, individuals, society, mind and self are dynamic and constantly undergoing change. However without shared meaning, effective communication cannot exist (Blumer, 2004). Therefore, it is erroneous to assume that, as citizens of a Sub-

Saharan African country, Cameroonians have kept the same health communication expectations and practices held by their ancestors. The change of religious climate is shown by the fact that 40 percent of the population is currently Christian while just 40 percent of the population still practices indigenous beliefs (US Central Intelligence Agency, 2011). The goal of this study is thus to examine the cultural context in Cameroon, investigate the ways in which it influences health, understand how providers and patients conceptualize health beliefs, gauge providers' and patients' perceptions of their interactions with one another, and identify the forms of communication that challenge and facilitate effective patient-provider interactions.

RQ1: How do the assumptions of the Western medical model intersect with those of the native culture in patient-provider interactions?

RQ2: How do Cameroonian providers and patients conceptualize health and illness?

RQ3: How does Cameroonian culture, especially Native and Christian religious beliefs, influence the beliefs and practices of providers and patients?

RQ4: In what ways do the interactions between providers and patients incorporate narrative and dialogue?

RQ5: What are the differences between how providers and patients view the quality or ethical aspects of the health related interactions they have with each other?

Definitions

Throughout the development of this study key concepts will be used, with the following definitions.

Health. Within the traditional African context, health is an individual or group's state of well being, spiritually, emotionally, physically and socially. It is important to note that goods and

personal resources constitute an extension of the individual therefore the prosperity of the individual's material resources is also a part of his or her health (Mbiti, 1970).

Stories. Stories are defined as value-laden accounts and recounts of symbolic actions embodied in speech or in deeds, following a specific sequence, using time and place (Fisher, 1984).

Narratives. Narratives are cultural or social schemas resulting from the accumulation and repetition of similar stories emerging and accepted within a specific socio-cultural context (Fisher, 1984; Cragan & Shields, 1998).

Narrative medicine. Co-creation of narratives by patients and health providers is an attempt to bridge the patient-provider gap and improve health outcomes. Narratives can be spoken, written or performed (Charon, 2009; Sharf, 2009).

Values. Values are defined within the narrative paradigm as important characteristics or conditions embedded in the narrators' stories (Cragan & Shields, 1998).

Dialogue. Dialogue is an encounter between the self and the other, in which the self chooses to retract one's self in order to receive the other. The selfless response to the other constitutes the essence of dialogue (Levinas, 1996; Lipari, 2004).

Patient-provider interactions. Communicative encounters between providers and patients through the use of verbal and nonverbal symbols.

Religion. Religion is defined as the way people think about the universe and their attitudes towards life. Religion is comprised of beliefs, practices, ceremonies, festivals, objects and places, values and morals, as well as leaders (Mbiti, 1991).

Native religion. Religion focusing on the acknowledgement of a variety of spiritual beings among which the greatest spiritual being God is responsible for all creation. The Native

religion conceptualizes misfortune as a consequence of communal violence, or the breaking of a taboo, in which case retaliation or amendment are possible spiritually (Mbiti, 1970; Mbiti, 1991).

Christianity. This is a religion focusing on the belief in a Higher Spiritual being whose nature is love and whose greatest imperative is the need for individuals to love one another (Kierkegaard, 1995).

Syncretism. The bringing together of elements from different religious sources. It is important to note that the mixing of elements occurs in various degrees so that one of the religious sources may be dominant, affecting the elements taken from the other religion (Droogers, 2005)

In order to better understand the needs related to Cameroonians' health beliefs and patient-provider interactions, my study was conducted within the Cameroonian context. I took field notes while observing health care processes, such as patient-provider interactions taking place in urban and rural health care settings. Second, I conducted indepth interviews with patients and doctors focusing on accounts and recountings about their conceptualization of health and their perceptions of health care and interactions. A complete explication of the method appears on chapter 3.

Dissertation Preview

My dissertation developed as a result of my own interests and experiences, my review of the literature and my observations and interviews with providers and patients in Cameroon. Chapter 1 provides a goal and problem statement located in my assumptions and definitions. To ground my study in culture and health communication research, chapter 2 reviews the literature on Cameroonian culture, health beliefs, Native and Christian religious beliefs and healing practices, patient-provider interactions, narrative medicine and dialogue. Chapter 3 sets forth the

methods and procedures I used when I conducted my interviews with patients and providers in Cameroon. Chapter 4 provides a thematic analysis of my interview data concerning health beliefs. Chapter 5 offers a thematic analysis of the quality and nature of the interactions. Chapter 6 interprets the data according to the research questions I posed. Chapter 7 provides theoretical and methodological implications and offers directions for future research.

CHAPTER 2:

LITERATURE REVIEW

Explanations of the concept of health often are made without locating health in a context and by presupposing the concept of health is universal; however, this is not the case. In most countries in the Northern hemisphere, the concept of health originates from the time where clergy played an influential role in the conceptualization of social activities (Engel, 1992). People kept issues pertaining to the body separate from the spirit and the soul. The early compartmentalization of the body in relation to the rest of the person was the point of view of the biomedical system, which generally equated health with the well being of the physical body. Recent revisions of the concept of health within countries from the Northern hemisphere also suggest that good health means that all of the individual's psycho-social aspects--psyche, body and emotions--are well (Roter, 2000; Helman, 2007). On the other hand, within the traditional African context good health refers to a state of emotional, social, psychological, physical and spiritual prosperity (Mbiti, 1991; Leonard, 2009). Some African scholars also associate good health with possessions; that is, if some person's material possessions are endangered and so they go to their local healer and get the necessary prescriptions (Mbiti, 1991). Therefore, the practice of humanistic care giving in Africa needs to pay particular attention to the communication between the provider and the patient, so that the patient and the provider exit the encounter feeling loved and cared for especially in the context of Cameroon.

The foregoing definitions imply that communication about health and within the health care context differ from one part of the world to another and from one historical context to another. Such observations suggest that the promotion of adequate care giving within a specific

cultural context requires an approach to health care receivers based not just on their health beliefs but on their values.

Accordingly, my literature review grounds my study in culture, health beliefs and health practices and interactions (dialogue). This review of literature (1) describes Cameroon as a context, (2) identifies health beliefs in Cameroon as rooted in religious and traditional beliefs, (3) explains patient and provider interactions as a micro context in which the health beliefs and values are manifested, and (4) describes communication practices necessary to explain communicative exchanges in the Cameroonian context.

Cameroonian Context

The name "Cameroon" comes from the Portuguese word "Camaroes," which means shrimp. During their exploration of the western part of the African continent, Portuguese explorers found a land with rivers populated by much shrimp. Thus, the Portuguese explorers named the region of Cameroon as "Camaroes." Following the Portuguese, German explorers transformed the name of the region to Kamerun; and with the last colonial powers, the French and the British Kamerun became Cameroun and Cameroon. As the French and the British colons discussed the segmentation of West Africa, part of Cameroon was allocated to the country of Nigeria while a smaller portion of the country remained Cameroonian under the British influence. The major part of the territory was put under the French colons after the first world war in 1919 (Laburthe-Tolra, 1988).

The Cameroonian territory is located just above the equator, on the gulf of Guinea, in the western part of the African continent but more precisely in what is now called Central Africa. Cameroon is part of an economic entity including the countries of central Africa (Bakoup & Tarr, 2000). The economic partnership with other central African countries, its agricultural

resources and its connection to the French currency has kept the Cameroonian currency at a higher exchange rate than other countries, such as Nigeria, who have opted for more economic independence. Unfortunately, despite its involvement in the bank of Central African countries and the relative importance of its currency, Cameroon remains one of the poorest countries of Africa.

Despite the slow economic progress and the limited infrastructural development, the population of Cameroon has shown considerable growth in the last century, reaching a population of approximately 18 million people. From the Foulbes in the northern part of Cameroon to the Bulus in the southern part of the country, Cameroon counts at least 500 ethnic groups and languages as of the year 2005 (US Central Intelligence Agency, 2011). It is important to note, that before colonization, West Africans used language and names in order to identify ethnic groups. Therefore, the political divisions of provinces, districts and counties used by colonial powers forced people who might have never considered each other as one to coexist. Similarly, groups who once identified as one nation have been separated as a result of colonial politics and rearrangement of territories.

Unfortunately, the establishment of various infrastructures, such as hospitals and other health facilities, also follow the new political system. Therefore, in rural areas the place appointed as the headquarters of a district sometimes benefits from a health facility, while other areas located away from the headquarters lack basic health infrastructures. Because the appointment of the headquarters happened because of colonial structures (Holloway, 2004), infrastructural design rarely took into account the cultural and ethnic divides. Thus, some people highly benefit from health care infrastructures, while others have to walk unthinkable distances in order to access Westernized health centers.

In terms of providers' availability, the service gaps between rural and city dwellings are no less than the distance villagers cover to access health facilities. Doctors, who graduate from medical school, dread the thought of being appointed to health centers or hospitals in rural areas (Fongwa, 2002; Einterz, 2001). Therefore, upon their appointments to areas remote from the main cities, doctors resist their appointments, hoping to be reassigned to an urban setting. Because rural areas are poorer than urban areas, the basic health care equipment needed in health centers is rudimentary if present at all. Thus the doctors have limited equipment, and patients with acute illnesses live in poverty-stricken environments that are remote. From a social perspective, health care providers find rural areas to be lacking in terms of opportunities; poverty limits their ability to explore any business opportunities or other lucrative activities outside of their governmental assignments. The governmental salaries are very low due to the economic crisis (Alibert, 1997), and so doctors find it difficult to rely solely on their governmental salaries to survive and care for their families. As a result of doctors' resentful attitude toward working and living in rural areas, rural dwellers often lack the presence of motivated and qualified health care providers (Fongwa, 2002).

In order to access basic Westernized health care, some rural dwellers have to plan overnight trips on the back of motorbikes or pickup trucks (field notes from trip to Cameroon). When their illness requires more than basic care, they find themselves traveling for several days in order to get to main cities where more adequate health care facilities or health care specialists are available (Fongwa, 2002). In cases where the patients need surgery or other more specialized care, the patients often need to go the capital city. The two main capitals, Yaounde and Douala, host two of the main public hospitals in the country: hospital La Quintinie in Douala and Central Hospital in Yaounde. Despite its lack of adequate infrastructures in comparison to national

hospitals in other countries, Central Hospital of Yaounde, hosts some of the best doctors in the whole country; it has doctors with international exposure and much experience in their specific areas of concentration (Hell & Hell, 2010).

While Cameroonians rely on Westernized health care, they also consult traditional healers in their local communities (Fongwa, 2002; Njamnshi, 2009). While the health care system is officially Westernized, informally traditional healers, as well as members of families with traditional knowledge on healing practices, also help provide health care. In order to better understand communication within the Cameroonian health care system, it is crucial to explore the health beliefs at work in the Cameroonian system.

Health Beliefs

This section of the literature review identifies the different components of the construct of health beliefs that are pertinent to the Cameroonian health context. Specifically, I examine research about the biomedical and holistic approaches to health because these two approaches coexist in the Cameroonian context where I conducted my study. Health beliefs can be defined as attributions that people create about health (Janz, Champion, & Stretcher, 2002). In other words health beliefs are the assumptions that we hold about the world that help us explain the nature and origin of our health issues or illnesses (Oetzel, 2009). The Institute of Medicine (2002) notes that the difference between beliefs from one group to another makes some people more likely to practice specific health behaviors, and the health beliefs of a population influence its motivation to engage in a specific behavior. Therefore, in a study of healthy behavior, health professionals ought to thoroughly understand the addressed population by looking at the individuals' backgrounds, the cultural beliefs' connection to health, as well as the individuals' health needs (Airhihenbuwa,1995; Andreasen, 1995; Cooper-Patrick et al, 1999; Witte, 1994).

The importance of the individual's health beliefs as illustrated by a health belief model (Bandura, 1977), accounts for the individual's perceived susceptibility to ill health, perceived severity of the health condition, perceived benefits in engaging in a suggested behavior, perceived barriers to engaging in the suggested behavior, cues to action towards the suggested behavior, and self efficacy that is the extent to which the individual can engage in the behavior. Besides the health belief model, the health theory of reasoned action (Ajzen & Fishbein, 2004) also implies the importance of the individual's health belief.

The theory of reasoned action (Ajzen & Fishbein, 2004) suggests that the individual's intention is the determinant factor for whether or not the individual chooses to engage in the suggested behavior. However, the individual's intention is influenced by several other factors, including the individual's attitude, the subjective norm about what others believe should be done and the individual's perceived behavior control. Therefore, in order to engage in a specific health behavior, a person would have to be intentional about it, yet their intention is partly a function of what they believe to be right or wrong based on what other members of the community believe.

The health belief model and the theory of reasoned action both suggest the importance of the individual's belief. But as in several other health communication theories, these theories were created in the Western context where the assumption is that the responsibility of health or ill health rests with the patient. Moreover, in the West health is mostly conceived as physiological and possibly social, but rarely metaphysical (Robinson & Nussbaum, 2004). Therefore, the major assumption behind these Western theories is that the patient can and must take the necessary actions in order to enjoy better health. Self efficacy can be achieved (Bandura, 1977) because health is understood as physiological or social, and most of the time the suggested behavior fits

the cultural context. In a different context, specifically in traditional Africa, understanding of health and of one's responsibility for health, lies heavily on the neighbor or the other in a metaphysical reality.

The traditional African world is different from the Western world in terms of the ontological assumptions in which health care is located. Despite the historical changes before and after colonization, traditional approaches to health remain part of the social reality in countries such as Cameroon (Rosny, 1985). The notion of a metaphysical world that members of the society can access, to the detriment of another one's health, is a unique characteristic of the African health care context (Mbiti, 1991). In order to better understand the differences between Westernized approaches to health and African approaches to health, it is important to look at the biomedical conceptualization of health which originates in the Western world, and the holistic conceptualizations of health in Africa that allow metaphysical factors into the understanding of the individual's health. Because Cameroonian providers and patients are exposed to Westernized approaches to health through education and holistic health through indigenous traditions, it is critical to keep in mind that a patient and a provider can favor either biomedical or humanistic approaches, or they can even value both approaches at the same time.

Biomedical Approaches

In their approach to health care, Hahn and Kleinman (1983) define biomedicine as a medicine, which "focuses primarily on human biology, or more accurately, on physiology, even pathophysiology" (p. 306). Biomedicine is the version of bio-medicine founded and dominant in Euro-American societies and spread widely elsewhere. In other words, Hahn and Kleinman suggest that by definition, biomedical approaches to health originate in the Western world and undoubtedly in the Western epistemological worldview. Some of the values that characterize

Western epistemology include syllogistic reasoning and the need for individuals to organize their thoughts in a linear, structured and scientifically explainable way. Epistemologically, biomedicine is characterized by its tendency to separate the patients' body, mind and soul (Schreiber, 2005).

Engel (1992) looks at the historical origins of the Western reductionist approach to biomedicine and provides insight into the early conceptualizations of health and disease, according to which medicine is a discipline and physicians are to respond to the social needs by addressing the onset of any disease that is socially disagreeable. The reasons for the evolution of biomedicine as reductionist were tied to Christians allowing the biomedical professionals to dissect the body, since Christians considered the body to be weak. However, "the Church's permission to study the human body included a tacit interdiction against corresponding scientific investigation of a man's mind and behavior" (p. 320). Thus, Engel notes that the dualism existing between the mind and the body was firmly established by the early Church, while classical sciences readily encouraged the notion of "body as machine, of disease as the consequence of breakdown of machine, and of the doctor's task as repair of the machine" (p. 321). Despite the later modern turn of biomedicine towards the understanding of health in terms of both body and mind, ignoring the behavioral and psychosocial aspects of health was common until the beginning of the 20th century. Physicians continued to look at the emotions as a separate element in relation to the patient's health. Engel (1992) notes that the official exclusion of the behavioral and the psychosocial aspect of health as suitable within scientific research, considering the fact that adequate methods and concepts for dealing with the excluded areas were still nonexistent. Later development of medicine within the Western world still continues to show the influence of the early religious dualism that influenced biomedicine.

In the Western world, the cause of disease tends to be attributed to an attack by an external pathogen or other directly responsible agent. Consequently, biomedical practitioners provide a diagnosis on the basis of observed patterns of symptoms among patients and the symptoms are observed and studied through the use of scientific methods. Assumptions specific to biomedicine caused the practitioners to assume that disease takes the same form and runs the same course in all its victims so that the cures and plans are essentially standardized (Shreiber, 2005). The mode of implementation of biomedical medicine involves the use of pharmaceuticals and surgery in order to eradicate the cause of disease. However, if eradication of the cause of the disease is impossible, practitioners use direct treatment in order to control or eradicate the symptoms of the disease. Thus, biomedicine often focuses on crisis intervention with diseases instead of considering other ways to preserve health.

Biomedicine is an approach to health care that takes over and imposes itself on the patients and the community where it is practiced. Within the context of biomedicine, the effectiveness of treatment is demonstrated through quantitative double-blind experiments published in medical journals. Thus, those treatments that have not or cannot be subjected to these criteria are viewed skeptically. "Efficacy of treatments and health outcomes are determined by physiological and laboratory testing, judged against a statistical average defined as 'normal,' and reported to the patient by the physician" (Shreiber, 2005, p. 181). Clearly, scientific inquiry plays an important role in the biomedical model's epistemological approaches to health. Therefore, biomedicine is not as relevant to the concept of health in cultures like Cameroon that do not hold the same epistemological values as the ones upheld in /Western health systems.

Hahn and Kleinman (1983) also discuss biomedicine as a socio-cultural system, including a distinctive element that relates differently from other systems within the society. Hahn and

Kleinman note that biomedical practitioners believe that their domain is separate from morality, religion, social organizations or even politics. The perspective of biomedical practitioners isolates the notion of health to the physiological being of the patient, such that health can be controlled through the use of scientific methods applied to the body of the patient. Thus, in its original sense biomedicine is grounded in materialism.

The materialist theoretical approach to health suggests that our experience of the world is tangible or palpable. "Materialist theory posits that all phenomena or reality, including knowledge itself, are essentially material, that what may appear to be non material 'things' are not really so, and that all that there is to be explained must also be explained in terms of the material (and the only) world" (Hahn and Kleinman, 1983, p. 307). On the basis of the materialist theory, nonmaterial concepts such as "culture" and "metaphysical beings" are described as loose and in need of translation into material forms that can be observed or tested. With the development of science's materialism, the context of biomedicine evolved and new forms of positivism emerged so that closer connections between medicine and natural sciences became the norm.

Biomedicine remains scientific in its approach to health since it is grounded in germ theory, depicting the type of health care that finds its roots in natural sciences such as biology, biochemistry, and biophysics (Schreiber, 2005). However, Hahn and Kleinman (1983) suggest that social scientists currently distinguish interconnections between the various sectors of biomedicine, social organization and religion, connections that the biomedical practitioners often choose to deny or ignore.

Biomedical Health and Limitations

Biomedical practitioners often approach the conceptualization of health as physiological in conventional and orthodox terms, such that alternative ways to approach health are deemed unconventional or unorthodox (Schreiber, 2005). However, an anthropological approach to health care suggests that "any society's health-care system cannot be studied in isolation from other aspects of that society, especially its social, religious, political and economic organization" (Helman, 2007, p. 81). In other words, it is limiting to approach the concept of health by looking at evidence of wellness only in an individual's body because the political, social and spiritual aspects remain neglected. Biomedicine (Engel, 1992) is now faced with the challenge to expand its approach to disease and health without necessarily eradicating the considerable advantage of the biomedical approach.

Thus, despite its practical and effective approach, biomedicine reveals some possible gaps including the approach to diseases by looking at the smallest isolatable component, which might show a causal relation to the illness, and it assumes that a designated disease does not exist in the absence of interference at the biochemical level. The tendency for the scientific approach to health to reduce the causes of ill health to specific scientific causes does allow for prediction and generalization. At the same time, however, the approach may eliminate the possibility for other causes for the disease to be determined. Though he acknowledges the effectiveness and the importance of the biomedical approach to health, Engel (1992) notes that some biomedical methods such as laboratory testing might suggest the existence of a predisposition toward diseases like diabetes without the patient being necessarily ill. In this case, the perturbation at the biochemical level might not be sufficient to infer that the patient is ill. Thus, in this case in addition to the clinical data and the biochemical processes observed in the patient, it is necessary to conduct a "scientifically rational approach to behavioral and psychosocial data, for these are

the terms in which most clinical phenomena are reported by patients" (p. 322). As Engel notes, the exploration of psychological and social factors is critical in the case of diabetes because it allows the health care practitioners to determine whether and when victims of diabetes start to consider themselves or are viewed by others in their social circle as sick.

Also, the biomedical treatment of the patient that is exclusively directed at the biochemical anomaly does not necessarily restore the patient to health, even when scientific results show considerable alleviation of the anomaly. While Engel's (1992) suggestion for the modification of the biomedical approach to health care allows for the inclusion of a scientifically rational approach to behavioral and psychosocial data, the approach remains scientific and conditioned by rationality and scientific methodology.

Holistic Approaches

Within the context of Sub-Saharan Africa, Appiah-Kubi (1975) denounces the reductionist approach (as practiced in the biomedical model) to health care (p. 231):

> The unfortunate division between mind and body, spiritual and physical, sacred and secular, has reduced the expected impact of modern medicine on the African population in terms of their understanding of health and disease. Most traditional African societies regard illness as a misfortune which involves the whole person. This has a direct bearing on the relationship of the patient with the spiritual or super natural world and with the members of his society.

As Appiah-Kubi (1975) notes, the cultural relationship existing between the African patients and the society where they are located constitutes a critical aspect of health that is ignored by biomedicine. The notion of spirituality or religion is a part of the patient that in Africa

is typically connected to the notion of health, so that the patient from Sub-Saharan Africa conceptualizes health as encompassing the body, the spirit and his social network.

Despite its historical longevity, holistic health care is discussed in biomedical journals as the "new paradigm in health" (Ho, 2003) since it addresses the health aspects lacking in biomedicine. As Helman (2007) notes, "Anthropologists have pointed out that any society's health-care system cannot be studied in isolation from other aspects of that society, especially its social, religious, political and economic organization" (p. 81). This is to say that it would be inefficient or inadequate to approach health care within a community oriented group while ignoring the various values embedded within a specific society. In comparison to the Western approach to health care, holistic health care considers the aspects of health care that are ignored by biomedicine, specifically the social and the religious aspects of health. Helman also notes that in most societies a specific form of health care is privileged while the other forms of health care are less visible. In some societies scientific medicine is professionalized so that health care professionals such as doctors and patients and other providers of health care, can be identified as part of "health care subcultures" (p. 81). In the Western world, the notion of health-care subcultures then pertains to imported forms of health care involving its own professional providers and inside codes and rules for administering healthcare. However, in the non Western world, the health-care subcultures are indigenous to the society and not added on as some innovative health care practice.

Approaches to holistic health care attend to the individual as a whole being, considering the individual's spirituality. As Helman notes predominant health care systems exist in contrast with health-care subcultures. Within healthcare, she also suggests the existence of the folk sector as encompassing indigenous ways of healing and other alternative medicines that address the

spiritual being of the patient. Some of the professionals involved in this specific sector include "faith healers, gypsy fortune tellers, clairvoyants, psychic consultants, herbalists and wise women" (Helman, 2007, p. 109). These alternative ways to providing health care act as complementary to the existing biomedical medicine, which fails to address the metaphysical reality of some patients.

Within the African context, some patients take it upon themselves to address the limits of biomedical approaches. When conventional remedies fail and the patients' illness remains unresponsive to regular treatment, patients use recourse to priests and/or other traditional practitioners. Unlike in the West, in Africa, health is included in the whole "magico-religious" fabric so that health goes beyond the mere absence of disease (Appiah-Kubi,1975; Makhulu, 2001; Mbiti,1991).

As scientists studying the "placebo phenomenon," Hahn and Kleinman (1983) note the importance of belief within health care: "Belief kills; belief heals. The beliefs held by a person in a society play a significant part in both disease causation and its remedy" (p. 3). Hahn and Kleinman's observation as a result of their comparison between scientific placebo effects and "Voodoo death" leads them to the conclusion that the individual's choice to believe in a specific reality can have observable consequences on health. Such findings support the notion of connectedness between religious belief and health especially in African cultures where Voodoo, which is a type of mystical cursing activity, is practiced.

Native and Christian Religious Beliefs

This section reviews the literature related to Native and Christian beliefs by identifying Native and Christian beliefs patient to health, the sources of religious syncretism, and the role that religious beliefs play in health interactions in the Cameroonian cultural context. The

provision and maintenance of health care is an endeavor that changes from one context to another. Depending on patients' individual and/or communal beliefs, health providers must carefully decide whether to keep a Westernized biomedical approach to health care or move on to holistic approaches that are inclusive of the traditional beliefs held by members of the local community. In order to better understand health care needs in Sub-Saharan Africa, specifically in Cameroon, it is critical to look at the traditional and religious beliefs at work in the local conceptualizations of health care (Leonard, 2009; Mbiti, 1991).

The resilience of traditional African beliefs and its coexistence with contemporary beliefs is discussed by researchers studying the notion of syncretism. Droogers (2005) defines the notion of syncretism as the mixing of elements from different religious sources, highlighting the fact that "religious sources that provide elements for syncretism, do not necessarily occupy an equal position" (p. 465). Thus, even though traditional Africans might be open to new religious and health views, they might to various degrees still depend on their traditional understanding of reality (Greenfield & Droogers, 2003; Droogers, 2005).

Traditional West African culture is a site of dynamic experiential and metaphysical beliefs. At the core of traditional African understanding of life are strong religious beliefs which remain resilient even in the present time. The religious beliefs and customs tend to govern other aspects of life such as health care (Mbiti, 1991). Therefore, traditional religious leaders and intercessors care for the body, the soul and the spirit of community members. In recent decades, two-thirds of Africans adopted Christianity as their new religious belief system, while they continued to maintain part of their traditional beliefs and world view (Mbiti, 1991).

Traditional beliefs are non-Western attributions held by local Cameroonians in relations to their health, including assumptions and theories passed down by indigenous people from

generation to generation, in order to explain illness (Mbiti, 1970; Mbiti, 1991; Janz, Champion & Stretcher, 2002). While religious elements of African Native religion, such as God as Supreme Being, are the same in Christianity as in traditional beliefs, other notions such as love and self-sacrifice constitute a clash of beliefs from one religion to the other. In order to gain a better understanding of the present psycho-social health climate within the context of sub-Saharan Africa, it is important to look at traditional African health beliefs, the current predominant religious beliefs in Africa and the implications that the traditional and contemporary beliefs have for the existing health care system.

Native Religious Beliefs about Health

The African health belief system is intrinsically connected to the notions of African spirituality, social life and financial well being (Mbiti, 1991). Thus to lack good health is to become a victim of enemies of good health that can be natural forces, such as droughts, and supernatural forces such as witches and spirits. When people experience ill-health, they usually attribute the responsibility to someone else, usually someone from the family or a neighbor of the victim. According to Mbiti (1991), the negative use of magic, witchcraft, usually causes domestic tensions such as jealousy or bad neighborhood relationships. If there is a quarrel between neighbors or relatives, a person might decide to get rid of another person through the use of mystical forces. In the same manner, if misfortune occurs after a heated quarrel, the rest of the community will likely suspect the other party as the cause of the misfortune through magic.

A common traditional belief is that a person uses evil powers to cause ill-health to his or her victim. Specifically, Africans believe in the existence of a spiritual and mystical world as well as the existence of individuals who have the knowledge and the skill to manipulate and use these forces for good or evil. The fear is that the more knowledgeable people, sorcerers and

witchdoctors, will use their knowledge for harmful ends, thereby causing misfortune to members of the community. The hope is that the sorcerers will use their skills for good ends so that magic will no longer be a curse but works as medicine. In most cases witches and sorcerers are perceived as enemies of health, but when they hold the title of medicine men, herbalists, diviners, mediums, and rainmakers or priests, they are perceived as helpful to those with ill health. Therefore, the use of magic refers to destroying, saving or protecting others. Magic can be a medicine or a curse, and medicine men and witches can be health providers for those who believe in their power (Mbiti, 1991). As Geshiere (1994) relates witchdoctors who are put on trial are often accused when they wish death on a specific person, throw a curse on the target and the person eventually dies. This was the case with witchdoctors from East Cameroon who had cursed a school director to death and spiritually prevented the local visit of a Catholic priest.. Interestingly, the prosecuted witches were identified by a traditional healer who called himself a "professeur guerisseur" (p.327).

The community perceives magic as positive when it helps the community members to find answers to misfortune, because people are not satisfied with knowing how misfortune happens. They also want to know who in the community caused it, when it occurred and who is responsible. People's belief in magic and its power to expose evil is a restraint for some people who may have been tempted to engage in questionable behaviors such as stealing. The fear that the victim of theft may use mystical force to retaliate keeps members of the community from misbehaving. People make positive use of magic to counter or neutralize the evil caused by another community member, to cure the cause of ailments, and to keep things from going wrong and even to keep someone or their possessions from being harmed (Mbiti, 1991).

Health as Prosperity

In some cases, people rely on medicine to bring prosperity and good fortune. They believe God is the greatest source of medicine amongst Africans. In extreme despair provoked by natural disasters-droughts, floods, earthquakes or famines-people are in great need of medicine. When natural catastrophes occur and deprive community members of food and other vital resources, some people turn directly to God. However, others turn to God only when all other forms of help such as medicine men and herbalists have failed. Whether medicine is actually effective is not the question; however, the belief in the power of the medicine is most important for understanding African traditional healing. Since, the main use of medicine is to alleviate emotional, psycho-social and spiritual pain, then the belief in the power of the medicine itself fulfills the essence of the need (Mbiti, 1991). In other words, Africans attribute much value to medicine; by merely using medicine their need to feel safe is fulfilled.

Traditional Healing

A key illustration of African traditional beliefs is the healing ceremony. In the Douala tribe of Cameroon and during the ceremonial healing, the leader of the ceremony is the healer who acts as the intercessor and performs the deliverance process by spiritually leaving his own body and going to the place where the patient is held spiritually captive. In the meantime the body of the healer lies inactive as does the body of the patient. Once the healer's body comes back to activity, the performance of a dance led by the healer in the company of the sufferer symbolizes deliverance for the ill person (Rosny, 1985).

African healers. Healers are individuals who have undergone the appropriate initiation in order to intercede on behalf of those in need of physical, spiritual, financial and social health. Thus, as mentioned previously, health providers have specific spiritual skills that are only detained by the initiated. One of these skills includes the "open eye," which allows the individual

to discern spiritual occurrences that regular individuals are not able to see and apprehend (Rosny, 1985, p. 248; Geshiere, 1998). Considering the fact that most, if not all, ill-health and misfortune find their root and explanation mystically, healers are perceived as invincible since they have the ability to see misfortune or ill-health before it is manifested and they have the power to prevent it (Rosny, 1985; Appiah-Kubi, 1975). The initiated can be members of foreign cultures including Western cultures holding Christian beliefs and Western leaders of churches. For example one French priest was told by a Cameroonian: "I am too simple, but if a priest, like you, had his eyes opened, there'd be nothing anybody could do to him" (Rosny, 1985, p. 247).

Therefore, in traditional Cameroonian beliefs, specifically in the coastal region, the notion of spiritual power is encompassing and welcoming of other beliefs. In the previous case, the spiritual power of a priest is welcomed and aided by an additional spiritual power to that held by healers. In other words the acquisition of spiritual powers from various sources results in an exponentiation of power for its owner. The ability to see in this sense is a tool that the health provider uses in order to discern what evil threatens his or her patients, while for someone else such skill might serve another function. Thus, the purpose of initiation and the gaining "open eye" is for the initiated to be able to see the acts of violence occurring around them (p. 248). While this might appear obvious to Westerners "in traditional society, everything conspires to conceal violence" (p. 248). Beliefs in violence in causing spiritual harm continue to exist because patients who are unsuccessful at work, or in school, and those who are physically ill, continue to seek explanations for their misfortunes within the spiritual realm.

Social health is essential to Sub-Saharan African cultures such as that of Cameroon because, as in any other culture, this community creates structures such as sorcery in order to manage conflict and violence. Because conflict and violence is framed spiritually, social order

can be easier to manage than at the physical level, for this reason the role of healers, such as the Ngangas, is to engage in battle in the invisible world against evil in order to preserve social, physical and spiritual well being (Rosny, 1985)

Cameroonian healers. In the case of Ngangas, who are the traditional healers in Cameroon, access to the invisible can occur through dreams and visions. The title of Nganga is attributed to traditional seers in the costal area of Cameroon. Not only do they have the power to see activities in the invisible world, but Ngangas also have the power to access the invisible world in order to protect or deliver their patients from illness. Ngangas are perceived as "super-witches," who have the spiritual power of sorcerers yet they tend to use it for healing purposes (Rosny, 1985; Geschiere, 1998). "I sleep, and I see as in a dream the mistakes others make. Sometimes it comes from God like a light. And if this light appears a second time, ah, then I am happy. I see how I have to heal, how I have to fight in ndimsi" (Rosny, 1985, p. 249). In their sense-making of dreams, Ngangas refer to God as an important and legitimate source of their insight and their ability in evaluating the accuracy of dreams about ill people and their meaning. The healers' ability to discern spiritual violence and their capacity to manipulate outcomes based on spiritual insight makes them socially suspect and often ostracized. Paradoxically, as much as people refer to Ngangas for deliverance from evil powers, these healers are also often stigmatized as potential threats because of their exclusive abilities to manipulate spiritual information. Being initiated as a traditional healer allows a person in a sense to choose a form of social self-sacrifice to prevent violence and uphold the health of the community. With the Cameroonian financial crisis (Alibert, 1997), the number of traditional healers increased and they now form a type of private health sector. This should not be surprising because as Fongwa

(2002) suggests “many citizens turn to traditional healers and birth attendants when the formal healthcare fails to meet their needs” (p. 326).

For the people from the coastal region of Cameroon known as the Doualas, the traditional healing ceremonies are not constrained by the concept of time or the need for certainty. People including the patient and the family trust the healer to lead the ceremony and manage the health care information for the patient. From a Western perspective, the healing ceremonies are described as disorganized and unstructured because no one but the leader of the ceremony knows exactly the details of the healing process. However, for the locals who partake in the procedure, the uncertainty and the overall fluidity of the healing activities are part of the custom. The health provider is in control and family members as well as friends are willing to give of their time and support to see the patient healed (Rosny, 1985). Because of the resilience of Cameroonian Native traditional culture, such practices continue to take place today. Geshiere (1994) explains that witchdoctors continue their activities in modern day Cameroon, especially in the Eastern part of the country which he personally visited.

God as healer. While in many African cultures the concept of healing depends upon the presence of a human healer, among some of these cultural groups God himself is perceived as a nurse, providing care to his people in need as a mother would provide care to her children. For example, in the Shilluk tribe’s prayers, people refer to God as the one who make the sick rise. “He is the great physician of mankind” (Mbiti, 1970, p. 65). While God is conceptualized as the main health provider, people in other cultures such as the Chaga believe that God is sometimes assisted by other spirits in the curing of the sick. The Ilas, another cultural group, believes that when the patient is very ill the head of the family must give material sacrifices in the form of food to gain favor and good health for the suffering, while the Leles believe that God gives

power to people such as traditional doctors and diviners to heal barren women and the sick. Across the multiple beliefs, God remains a part of the healing process, whether alone or with the help of physical or spiritual assistants. These beliefs about God persist amongst some conservative native communities; however, some Cameroonians choose to mix their Native beliefs about God with the beliefs acquired in Christianity.

Healers, calling. Traditional healers, in ways similar to Christian priests and pastors, have a calling. The vocation of the traditional healer originates from a complex source. While in some cases, children receive the profession of medicine men from their parents; in others, people feel called to become medicine men or women. The calling usually happens through a dream or through constant interactions with a spirit, especially the living dead (Mbiti, 1970). Once they are called, the medicine men starts working with a skilled healer in order to learn. The learning process can take up to a year. In cases of minor incidents, such as simple cuts or headaches, the medicine men will prescribe appropriate herbs; however, when health issues are more severe and persistent, the medicine man uses his spiritual knowledge and power to assist the patient. In the latter case, the medicine men will prescribe specific religious observances for the patient to recover. The medicine man serves as a healer and a religious leader in his community. Counseling and intercessory prayer are other activities that medicine men engage in on behalf of their community. Some people go to them when their children misbehave or when they are going on long and important journeys. Thus, medicine men are people who sacrificially dedicate their lives to preserve their community's welfare using their technical and spiritual powers. Such endeavors involve investment in terms of time and possibly loss in terms of social welfare; however, the duty to follow their call obviously supersedes the sacrifice (Mbiti, 1970; Rosny,

1985). Contemporary accounts pertaining to these traditional vocations suggest that the "gift" and responsibilities of healers are usually passed down from one generation to the next.

Christian Religious Beliefs and Syncretism

More than half of the people within the African continent are professing Christians. However, some argue that Africans espouse a plural approach to life so that whatever beliefs work for the present situation will be the belief or beliefs that one embraces in a given circumstance (Ela, 1980). Within the context of Cameroon as a whole, the two major spiritual beliefs are Christianity and Native religions, but these are sometimes combined into a syncretism. Islam is practiced in some regions of the country but this religious group was not the focus of my study.

The arrival of Christianity came with colonization in the late 1800s (O'Neil, 1991). By the time British colonizers arrived in Cameroon, they found local catechists trained by former German colonizers. One example is Matthias Effiem, who was adopted by a German missionary after the death of his father. Later, he was trained and baptized in a school at Engelberg, returned to Cameroon, and served by building Christian missions and other religious infrastructure. Along with Effiem, missionaries took other boys and girls to German schools, and then baptized and trained them to return home and build missions.

However, the missionaries' efforts to change the belief systems of Africans did not always yield the colonizers' desired results (Ela, 1980). While missionaries baptized members of multiple tribes and Christianity propagated, African Native religious practices persisted both in rural areas as well as in urban African settings. Africans practiced Christianity simultaneously and Native African religion. Yet, it is important to mention that some Sub-Saharan Africans

cultivated a different approach to Christianity and Native religions than did people in other regions (Spear & Kimambo, 1999).

Christianity in Sub-Saharan Africa

One of the multiple examples of Africans' appropriation of Christian beliefs took place in Ethiopia and Kenya, where the Zionist churches developed. Zionist churches developed as a charismatic Christian movement in congruence with African religiosity, based upon literal biblical truths and acknowledgement of the existence of spiritual gifts from the Holy Spirit (Spear, Kimambo, 1999). The Zionist movement sprang forth in Kenya in the late 1920s and 1930s. The movements emerged as a result of the crisis related to the female circumcision practiced within the cultural African context. The limited knowledge we have of the African Zionist movement suggests that this religious approach did drew upon traditional African religious heritage; however, the situation is more complex because the Zionists rejected some established Christian denominations also some local traditions. The Zionist movement focused mainly in a firm application of literal biblical interpretation that they used to inform their practice of prophecy and other spiritual gifts. Some believers of the Zionist movements formed the Aragi movement. The Aragis refused to take oaths because they could not reconcile the Zionist theology of some of the missionaries with the teachings of the gospel of Jesus Christ. The Aregi Zionist leaders also used biblical teachings to criticize the people's traditional belief in ancestral spirits, which they judged incompatible with biblical truths.

Reports on African religious movements show that it is simplistic to conceive African religious approaches as merely pluralistic, because some Sub-Saharan African movements, such as the Zionists, emphasized the great relevance of the view on the New Testament truths. The case of Christianity in Cameroon is relatively unique to Africa. While the notion of care

remained from the introduction of Christianity in Cameroon until today, the practice of selflessness, following in the footsteps of Christ constitutes a perpetual challenge (Mamia & Massaga, 1999). Even though Christianity is the dominant religion in Africa, and it shares as much importance as Native religious beliefs, following in the footsteps of Christ continues to be a challenge even for Cameroonians and other Africans who identify as Christians.

The Christian God in Cameroon

Today, Christianity is one of the two leading religions in Cameroon, rivaled by Native religion both followed by Islam. However, within Christianity a variety of denominations distinguish themselves in terms of beliefs, styles of worship and/or doctrinal emphasis. The mainstream and most recognized divisions are Catholics and Protestants. Within the Protestant churches, some of the largest denominations are Presbyterian, Evangelical churches, and Baptists (Akoko, 2007; Laburthe-Tolra, 1988; Messina & Slageren, 2005). To gain a deep understanding of Christianity in contemporary Cameroon, it is critical to acquire some understanding of how Christianity was introduced in the country, what major Christian churches believe and how the churches' beliefs evolved to the present day.

Protestant Missions. The discovery of Cameroon was closely followed by commerce where Cameroonian merchants traded ivory and palm oil in exchange for release from the threat to be taken as slaves (Laburthe-Tolra, 1988). It is in this atmosphere that the first missionaries from the Basel mission entered the coastal region of Cameroon, often ill-trusted both by the locals and the colonizers. Basel missionaries belonged to a European organization of Christians united to bring the gospel to non-Christians right after the abolition of slavery. The Basel organization involved missionary workers from Europe and the American continent, such as African Americans who desired to bring the gospel to the continent of Africa. In June 1845,

Alfred Saker, a German Baptist missionary, performed the first Cameroonian baptism. He was followed by the Jamaican missionary Alexander Fuller. Both religious leaders used an exceptional approach to evangelism; they taught the locals how to make bricks in order to build stronger homes as well as how to plant new crops that were more nutritious and appropriate for the local weather than before. This approach, which illustrated a tangible connection between religion and community development, was ultimately welcomed and cherished by the locals (Laburthe-Tolra, 1988).

Following the early introduction of Christianity in Cameroon, a Cameroonian king of the coastal area wrote to the Queen of England, pleading for the Queen to take leadership over the region and thereby give Cameroonians from the coastal region a way out of superstition and traditional spiritual beliefs and into development. Despite all the political uncertainties, going from one colonial rule to another, Cameroonians' expressed a desire for economic development that matched their adherence to Christianity. Years later, as more missionaries from the European Basel mission entered the country and pressed into the continental region of Cameroon, more Cameroonians were awe-filled by the power and the prosperity of the Western religious leaders. While the colonizers used force to take over the region, Basel missionaries built schools, churches, and taught eager Cameroonians, who saw in the missionaries successful and almost supernatural beings holding the secrets to economic development (Laburthe-Tolra, 1988). The baptism of Cameroonians thus occurred as part of their educational curriculum.

The Catholic missions' presentation of the gospel of Christ as part of a greater educational whole was paralleled in the work of the Catholic mission in Cameroon. While the Protestant missionaries covered mostly the coastal region of Cameroon, Catholics interacted with the "Beti," a Cameroonian tribe whose members often traveled considerable distances from the

deep central forests to South western Cameroon (close to the coastal region) in order to work for the Catholic mission. Several Betis worked voluntarily, and when time permitted, the missionaries taught them about Christianity (Laburthe-Tolra, 1988).

The Protestant missionaries and believers criticized Catholics, accusing them of perpetrating colonialism for exploiting Cameroonians as well as their fields. However, Catholic missionaries lived by the motto "Cruce et Labore," that is, by the cross and by work. Catholic missionaries often worked alongside Cameroonians teaching them various working skills such as carpentry. Traditionally, the Beti people did not separate economical prosperity/development from the spiritual powers responsible for bringing the financial blessing. Therefore, working with the Catholic mission and making a good living while adopting the Catholics religious beliefs made perfect sense. For the Betis, prosperity and success start in the invisible, the religious, and the metaphysical. If the missionaries were so successful, lived comfortable lives and knew so much, it would be wise to adopt their religion (Laburthe-Tolra, 1988).

After finishing his western education with the Catholic mission, Karl Atangana, a member of the Beti tribe, became a leader in the Catholic Church as well as the emperor of the Beti people. When asked why they chose to convert to Christianity, some of the Beti people stated that they did it because Atangana said so. During his rule, Emperor Karl killed several witch doctors that opposed and threatened Catholic missionaries or his own rule. Ultimately, resistant community members and leaders accepted Christianity and aligned themselves under Karl's leadership. Some of the Beti Catholic converts even declared, we would like to sing German hymnals at church; if we are going to use our drums and our traditional/old songs then we might as well remain pagans. While such a statement could not be generalized to the whole Beti population, it seems to provide some insight into the struggle for identity and the relevance

of Christianity for Cameroonians after they gained independence from colonial rule (Foussouo, 2008). This convergence between Christian and Native beliefs is as common in contemporary Cameroon as it was in the colonial period.

Urbanization and the Need for Leadership

The end of colonization made the Cameroonian identity crisis more manifest in various sectors of society including religion. Some members of the Christian churches hoped to see their fellow Cameroonian church leaders integrate traditional ways of thinking into the church, as well as accommodate Native religious leaders who held traditional responsibilities (Messina & Slageren, 2005). The traditional communities were falling apart, while most Cameroonians migrated to the urban areas, leaving rural dwellers without leadership. Cameroonians capable of stepping into leadership position were exclusively part of the Christian church and waited for approval of the new church leadership to hold dual leadership both in the Christian community and the traditional community.

Reverend Kanseng, who was a Cameroonian leader of the Presbyterian Church in Cameroon, was asked to become the sacred ruler of his native community (Foussou, 2008). After much thinking and praying, Kanseng decided to accept the position of sacred ruler under strict conditions: he was going to abide by the conviction of his Christian faith and was going to continue to fulfill all of his duties as a leader in the Presbyterian Church. Some of his conditions included not taking any additional wives, and not partaking in rituals that were contrary to his Christian faith. The locals warmly welcomed his conditions and were grateful to Kanseng for meeting their need for leadership and care. They also asked him to teach them about his Christian God. Seemingly, even after their independence, Cameroonians remained open to Christianity as long as it accommodated their need for development and religiosity. While some

Christians highly resisted Kanseng's decision, several praised his choice as a powerful means to show that Christianity was not changing or rejecting who you are but subjecting who you are to Christ–while loving and caring for people where you are (Foussouo, 2008; Messina & Slageren, 2005).

Caring for the needs of believers is a theme that persists in the contemporary Christian churches, 50 years after the Cameroon's independence. Even in the Presbyterian and the Catholic churches, which were reputed for keeping the traditional worship style instituted first by European missionaries, some congregations later adopted a new approach to Christianity that stresses the role of the Holy Spirit for the protection and healing of the people. Akoko (2007) calls it the pentecostalisation of mainstream churches. The Pentecostal movement, which originated from the United States in the early twentieth century, gradually infiltrated the African continent, showing phenomenal growth in the last two decades. Researchers (Akoko, 2007) believe that the hallmark practices of Pentecostalism, such as dealing with evil and misfortune, have gained the movement favor with the African public acquainted with misfortune and the need to prevent it. Some of the doctrinal tenets of Pentecostalism include: "an emphasis on salvation and justification by faith, the doctrine of the second coming of Christ, the stress on spiritual healing, and the doctrine of the baptism of the Holy Spirit symbolized by speaking in tongues and expressed in the story of the Pentecost in the Acts of the Apostle" (p.300).

Even after independence from colonial rule, religious movements such as the Pentecostal association were restricted in their access in Cameroon; the only official religions were Islam and (Protestant and Catholic) Christianity. Protestantism was limited to the denominations introduced by the missionaries during colonial time. Several decades after independence, the president of Cameroon voted new policies that waived the restrictions for parties and associations such as the

Pentecostal organization. New Pentecostal churches became crowded with Cameroonians. Because Pentecostal churches are an organization that provides jobs and training opportunities only available to its members, researchers believe that some members join to have the opportunity to work (Akoko, 2007). Some new Pentecostal churches took membership away from mainline protestant churches because they offered an economic incentive to the people.

Soon the mainline churches, such as Presbyterians, Catholics and Methodists, started to include some of the Pentecostal practices, mainly prayer and healing, since African congregation members still believed in witchcraft and in curses and diseases. The congregation members needed activities that were relevant to their local beliefs and realities. Some pastors of the Presbyterian Church were asked to resign for over-emphasizing and attempting to implement Pentecostal practices, such as the baptism by immersion and the need to be born again. In order to be called "born again," congregation members were asked to publicly confess their state as sinners and solemnly give their life to Jesus. After some time of observation, leaders of the Presbyterian Church found the Pentecostal practices divisive, and leaders promoting the Pentecostal movement left their original congregation taking with them part of the previous congregation's members (Akoko, 2007).

Despite the split that occurred in mainstream churches, influences of the Pentecostal movement remained, especially amongst the church youth groups. Some Presbyterian churches, such as the Presbyterian church of Moliko, adopted several forms of Pentecostal practices mainly singing and dancing of congregation members during offering time. Other congregations in main line churches started prayer groups for the healing of the sick as well as deliverance ministries. The desire to implement practices that better address the cultural needs of the Cameroonian population is evident in several Christian churches across Cameroon suggesting that Christianity

is centered on the notion of caring (Akoko, 2007). Placing healing services within Christian churches accommodate cultural beliefs about religion and health.

Christian Belief

In light of the identity crisis faced by the church in Africa, Mamia and Massaga (1999),who are leaders of the African Protestant Church Association, suggest a new way of being church. Mamia and Massaga believe that God meets each human being fully, denying no one of his or her identity. Christianity is defined within the context in which it is practiced therefore the ways of worship and the structures implemented to facilitate the encounter between God and men are only receptacles that change from one cultural context to another. Mamia and Massaga note that "religion even if it is Christian is not enough to put us in true relationship with God" (p. 242). The relationship with God comes first, and religious practices are used as a structure to support the relationship. Therefore, it is important to keep religious needs and feelings as separate from the message of Christ. Nonetheless, the churches are places where health beliefs are integrated with the Christian faith tradition and the New Testament scriptures.

Mamia and Massaga (1999) discuss Christianity as following the footsteps of Christ who did the works *of* His Father, instead of merely doing work *for* the Father. While doing work for the Father, the individual can get lost in the details of the structure, religious practices and rule making *for* the Father, while missing the work *of* the Father. "Thus the global vision of God's reign calls persons to offer up actions in the name of the gospel. These actions are made meaningful in relations to the whole plan rather than themselves" (p. 244).The acts that are posited in relation to God's plan on the earth are to be selfless (Kierkegaard, 1995) if they are to powerfully bring about the Kingdom. The selflessness in these sacrificial acts is conducive to fulfilling patient and provider encounters and ethical dialogue.

In their suggestion of a new way of being church, Mamia and Massaga (1999) discuss important tenets based on Jesus' model of life on earth. The tenets emphasize the importance of culture, respect for God's creation, the duty to nourish others, the duty to provide health, the need to watch over human relations, the duty to implement justice according to God's way and the need to be festive. Among the previous tenets two are of major interest for the present study: the duty to provide health and to watch over human relations.

Christianity, Health and Communication

The connection between religion and health is a dominant feature of Cameroonian culture. Mamia and Massaga (1999) explain that God is concerned with our health. This is illustrated by Jesus as he heals the sick in proclamation of God's reign. "Health includes a variety of aspects: prevention, hygiene, traditional and western medicine, intercessory prayer for healing and the purification of a place or environment" (p. 249). This notion of health encompasses of the physical as well the metaphysical realm, and it reconciles aspects of traditional medicine with Western medicine. Intercessory prayer is directly relevant to the religious context and is mentioned in scripture, and it combines physical, metaphysical and social health.

Communion, compassion, and health. In terms of human relations, it is important to move from deeds of mere kindness to an attitude of communion and compassion toward others. The practice of care can flow from kindness while love comes from the desire to commune, becoming one with the other person. The biblical notion of communion with others exceeds the notion of care that is usually practiced within the African context. Traditionally, Cameroonians care in order to maintain social harmony and act as good community members. However, the notion of communion requires the individual to reach beyond self and become one with the other

person, embracing the person. Communion is modeled in the teachings and deeds of Christ, who met the needs of the neighbor by knowing them, becoming one with them, forgiving them of their sin and reconciling them to God and himself while making them whole physically and socially. Thus loving instead of merely caring requires an attitude of communion with others where one is willing to put the message and attitude of Christ first and the cultural structure second (Mamia & Massaga, 1999).

The practice of Christianity involves the worship of Christ as the model of love and shows a variety of applications as well as controversies. Besides, the traditional beliefs and philosophy that promote spiritual violence, the relatively forceful introduction of Christianity for local believers produces ambiguity and confusion in understanding Christianity, love and health (Spear & Kimambo, 1999). While some Cameroonians seek to understand Christianity in the African context, the temptation to focus on the cultural mold inherited from Western missionaries remains a distraction to the message of love and communion modeled by Christ. Thus the life application of communion is challenged by the pull from tradition, Westernized religion, as well as from the biblical message of love (Kierkegaard, 1995). The African traditional conceptualizations of health, the complex religio-spiritual reality and the contemporary church's focus on communion are influences that Cameroonians undoubtedly bring to the patient-provider meeting in order to make sense of the communicative encounter. The sense making of patient-provider encounters relies on the sending and reception of messages during the interactions. Patient and provider encounters are of interest because they provide unique opportunities for Cameroonians to reproduce traditional and/or religious beliefs. It is insightful to explore the nature of interactions between professional health providers and patients in the general health care context.

Patient-Provider Interaction

This section of the literature review considers research pertinent to patient-provider interaction in Cameroon. Specifically, I examined the research about the biomedical model and its influence on health exchanges, the quality of caring exchanges, and the role that narrative plays in these interactions and exchanges. At the heart of patient-provider encounter is the communicative exchange that takes place between the two parties. Therefore communication practice is not only part of the patient-provider construction of reality, but it is a critical element in the enactment of health beliefs and the provisions of care. The effective delivery of information and the process of building trust are both dependent on communication practices (DiMatteo, 2004). The section will look at the nature of patient-provider exchanges in the general literature and the unique communication practice associated with narrative medicine and the dialogical features of the interaction.

Most research and theorizing on patient-provider communication have been conducted in the Western context where the biomedical model of science-based diagnosis and treatment prevails. Nonetheless, patient-provider interaction is a unit of analysis that emphasizes communication practices, and it is therefore a focus for this dissertation research. A critical element of communication exchanges is the micro context in which the encounter occurs.The exchanges that characterize patient-provider interactions are influenced by a variety of factors. Besides elements pertaining to the socio-cultural context in which health care is practiced, the biomedical model focuses on health providers' training and plays an influential role in shaping the communicative encounters between health care providers and patients (Li et al., 2007). My initial interviews with several local Cameroonian doctors and medical students suggested that the training of Cameroonian professional health care providers is usually done in a Westernized

health educational system. Depending on the personal orientation and medical training of health care providers, providers and patients can engage in biomedical exchanges, predominantly caring exchanges or exchanges that incorporate both.

Biomedical Exchanges

The notion of biomedical exchanges occurs during providers' consultations with the patients, when health providers ask and give mostly biomedical information that relates to the patients' physiological state in relation to their disease. Research shows that in countries such as the United States of America where providers are afraid of being accused of doing too little, patients tend to provide biomedical as well as psychosocial information because the health providers ask a high number of questions related to these areas (Jozien et al., 2003). Such exchanges tend to contain messages that are superfluous, extensive one-sided questions in the biomedical interviews, and a great emphasis on physiological health (Bonsteel,1997; Jozien et al.2003).

Within the context of patient-provider interaction as well as in the general communication context, health messages are communicative acts used by health providers in order to suggest a specific behavior that would enhance or maintain the patient's health (Mailbach & Parrott, 1995). Thus, the aim of the message is to provoke positive behaviors toward patients' health. Health messages are not limited to patient-provider interactions; some health messages are mediated, and others are transmitted through community members and social structures (Alexander et al., 2008). Research (Nilsen & Elstad, 2009) on health messages suggests that in any interactions people are faced with multiple challenges including putting thoughts and feelings into words in order to develop a shared understanding of what is happening.

In their attempt to reach a shared understanding of the patients' illness, providers tend to ask questions pertaining to the body of the patient, during a specific and objective time (Nilsen & Elstad, 2009; Du Pre, 2000; Du Pre 2001). The specificity of the providers' question and the emphasis put on the physiological reality of the patient helps the provider to narrow the possibilities for diagnosis. Therefore, when patients suffering from acute pain describe their condition to their health provider, and when the descriptions lack the temporal objectiveness expected by providers, then patients tend to lack trust in providers. Nilsen and Elstad's research shows that when patients experience difficulties describing the pain, attempting to use past experiences to explain their present pain, health providers have the tendency to try to pass by the voice of the patient in order to reach the point which is a problem in contemporary health interactions. Since the goal is the physical diagnosis, the encoding and decoding of health messages by providers often aims to treat or prevent the physiological ailment.

Health communication theories pertaining to health messages originated from the perspective of Western researchers using a scientific and physiological approach to health. Therefore health communication and health message theories aim at improving patients' physical health or preventing patients' diseases. This treatment approach to health care that affects the production of health care messages by health providers and guides the exchanges between doctors and their patients is learned by medical students during their professional training (Conrad, 1988).

Providers' Training

The medical school's curriculum used to train health providers focuses mainly on physiological health (Bonsteel, 1997). Therefore, most of the teaching provided to medical students emphasizes the technical aspect and the physiological state of future patients; the

emphasis is on disease instead of illness (Conrad, 1988). The nature of the training results in the students feeling that they have accomplished their medical school goals once they have mastered the technical and physiological intricacies of medicine. During their training, students face multiple challenges including sleeplessness, as well as struggles understanding the purpose and adequate administration of medicine. Based on academic resources for future health providers in France, the training of United States health providers and providers trained in France are similar (Gassier, 2000). Thus, the notion of bedside manners and humanistic medicine becomes secondary if at all relevant (Branch et al., 1991; Conrad, 1988).

Psychosocial Context

The high level stress present during the training of medical students and the lack of criticism for lack of bedside manners fosters an environment where the doctors and interns are overworked and too stressed to recognize patients as allies (Conrad 1988; Probst et al., 1997). Without directly stating their opinion on humanistic approaches towards patients, medical structures indirectly send a message that elevates scientific knowledge and implementation over humanistic care. Such messages are present even in the recruitment and selection policies of health care providers where not enough emphasis is attributed to caring behavior (Conrad, 1988). Students are not only bombarded with these non-humanistic messages about medicine, but they also go through inhumane conditions during their training, so that the psychosocial context characterizing the medical training conditions of the future doctors is less care oriented and more treatment oriented. Some medical institutions amended their curriculum in order to incorporate more training in bedside manners; however, despite the minimal changes in terms of medical school curriculum, patients' accounts of uncaring behaviors from health providers are still present.

Caring Exchanges

Caring exchanges are encounters in which the health care provider uses a humanistic approach towards the patient, addressing the patient as more than a mere body and acknowledging the patient's person and feelings (Charon, 2009; Conrad, 1988). While caring exchanges might seem unwanted by mainstream doctors trained under a biomedically biased curriculum, it is important to note that health providers admit to the fact that they would rather look at the patient as more than a mere body; however, the demands of the workload and the biomedical culture are taxing that they limit providers' ability to do so (Probst et al.,1997). Doctors' acknowledgement of their desire to adopt a humanistic approach suggests that caring exchanges are not only desirable for patients' but also for the providers of health.

Research (Conrad, 1988) shows that doctors who tend to acknowledge their patients holistically in caring for them also tend to be health providers who bring a caring attitude into their medical interactions. Such observations suggest that the caring attitude starts at the individual level so that one's personality and willingness to acknowledge the other's face (Levinas, 1996) constitutes a major factor in medical care. Thus, the need to select caring individuals as health care providers is deemed crucial to integrate a humanistic model into medical education (Roter, 2000).

The myth surrounding time and caring exchange was denounced in a research project conducted in the United States and Holland (Jozien et al., 2003). In the comparative study, results showed that health care visits where the provider acknowledged the patient holistically could be shorter than the typical biomedical visits. This phenomenon was explained by the fact that caring visits included less superfluous biomedical information and the necessary affective and caring exchange of information.

The need for caring exchanges between providers and patients is not only justifiable by the mere fact that both patient and provider desire them but also by the fact that these types of exchanges result in better health outcomes. Records show that when health providers used a caring approach towards patients, health outcomes improved positively and health care providers were more satisfied (Roter, 2000). When feeling cared for, patients are willing to communicate stories relevant to their illness and to the diagnosis given by providers. As a result patients show better health improving their overall wellbeing. For example, the caring approach creates improvement in the health outcomes with patients suffering from high blood pressure (Roter, 2000) and with more critical diseases, such as cancer (Dimatteo, 2004).

In the context of pediatric training, caring communication that involves trust building was deemed essential for ultimate better patient health outcomes (DiMatteo, 2004). Providers built the trust of their patients because they avoided making the patient feel judged and unsupported, and the patients perceived the provider as an ally. The building of trust is critical with patients suffering from illnesses that require their adherence to strenuous or frightening treatments. The perception of the health provider as an ally suggests that the health provider works in collaboration with not only the patient but the family of the patient in order to implement the remedy for a health condition. The building of trust requires genuine care and compassion from the health care provider who earns the confidence of the patient after showing that the patients' over all well being is the priority of the provider.

Caring Exchanges and Narrative Medicine

Literature on patient-provider interaction within a Westernized system shows the need for a caring and compassionate approach from health providers in their interactions with patients in order to achieve better health outcomes and to ensure the satisfaction of both the patient and the

health provider. The caring approach suggests the needs for the principle of love, putting the need of the other first as recommended by Buber (1966), Levinas (1996) and Kierkegaard (1995). In the context of a communicative encounter, such as the one between the patient and the health provider, communicative needs must be acknowledged to demonstrate care and compassion. Research (Nilsen & Elstad, 2009) shows that patients described very positive meetings when the health providers were caring, took the time to consider the patient's pain problem by listening to the patient's whole story, and when the providers explored continuity from past, present and future. The acknowledgement of patients' whole stories resembles advice of those providing medicine as a way to empathize and share the meaning of the patient's illness. This approach was proven to be a powerful medical tool in bridging the gap between providers and patients as well as enhancing care giving (Charon, 2009).

Narrative Theory

Considering the cultural elements at work during the interaction between providers and patients as well as the inherent values embedded in the accounts of both parties, narrative paradigm theory (NPT) provides a relevant and suitable approach to study the patient-provider exchange. Narrative theory explains the power of storytelling as it adds to the values as justifications for human action (Fisher, 1984; Fisher 1989). The symbolic artifacts used in NPT are value-laden stories. Thus, individual's values, those of providers and patients, constitute an important part of the health interaction, and Cameroonian providers and patients' stories are located in narratives that counter the objective scientific approach that typifies health encounters. NPT has the explanatory power to examine narrative messages as important part of health interactions in health contexts (Cragan & Shields, 1998).

Values. The power of NPT resides in its implicit and explicit values that are embedded in the effects of stories in interactions (Cragan & Shields, 1998). In some instances values are not directly stated by patients within the story; at other times they are implicit, requiring the listener or provider to interpret the messages and find the underlying values expressed within the patients' story. In other instances, the values present in the stories are clearly exposed by patients, and in those situations the explicit values should garner the attention of providers. The ability to examine values within stories constitutes an asset in the analysis of patient-provider interactions and of the ethical quality of interactions they engage in the contemporary Cameroonian health care, which is an amalgam of traditional African and Western health beliefs.

The main assumption supporting the theory is that humans have the innate ability to tell good from bad, moral from immoral, acceptable or inacceptable, and they embed these values in their stories (Fisher, 1984; Fisher, 1989). The ability assumes narrative rationality; that is, stories are useful if they are coherent messages told by patients and ring true with the story of listeners or health providers. The stories cohere if the arguments and evidence used in the story are interconnected and sensible to the storyteller and his or her listeners. Another assumption is that people, both providers and patients, are storytellers, that the messages they use in interaction are value-laden reasons for acting or believing, and providers and patients use their innate narrative logic to make sense of communication about health issues during interaction. Thus, the providers' and patients' cultural values are inherent to their storied messages, choices and actions.

NPT originated from Fisher (1984) who theorized that human values are central to interaction and the meaning making of interactants. Fisher looks at both logic and values in reasoning in order to the understand humans' symbolic reasons that underlie action and meaning

making. NPT includes three basic concepts: narration, logical and good reasons to create and believe a story and message content that features characterization, emplotment and place of presentation. However, the initial basic concept in NPT is narration or story, which is an accounting or a recounting of value-laden symbolic actions embodied in words and deeds showing sequence, space and time (Cragan & Shields, 1998). This definition of narration or story applies to a variety of contexts, including health communication, specifically patient-provider communication. Within the context of health care, health providers' messages identify curative and preventive measures in order to treat and protect patients from various ills. One important feature of health messages is for providers to acknowledge and understand values of patients and to connect the patients' values to their diagnosis and treatment. Thus, by their very nature health messages are value laden. In order to recommend curative and preventive health messages, health providers use their patients' stories as revelatory of the redemptive and moral values that constitute the fundamental purpose of each health care system to care for the patients' needs (Harter 2009; Sharf, 2009; Charon 2009; Thompson, 2009).

Narrative Medicine

Narrative as conceptualized in U.S. health research is relevant to the Cameroonian healthcare context because it applies to providers and patients as narrator-mediator, the capacity of health providers and patients to engage in dialogue, and the dialogical ethics that emerge when the providers and patients use narrative in their interactions. Recent scholars apply narrative approaches to the context of health care, emphasizing how health care provider's communicative attempts diminish the chasm existing between provider and patient. "Narrative medicine recognizes that the central events in health care are the giving and receiving of accounts of self" (Charon, 2009, p.120). This section explores how narrative medicine impacts the provider as

narrator-mediator, facilitates a co-creative understanding of the patient's condition, promotes patient-provider emotional vulnerability and is applicable.

Provider as Narrator-Mediator

Within the context of health care both patients and providers are storytellers; however, Charon (2009) suggests that as a provider of health, the doctor constitutes a mediator between the body and the self of the patient in order to bring a sense of reconciliation peace and well being to the patients. The body of the patient refers to their biological person, the visible and palpable body, while the self refers to the patient outside of his or her body. The use of narrative medicine allows the health provider to sit almost as a ghost presence and listen to the patient while he or she provides accounts of needs and feelings apart from his or her bodily condition. While the destination of the message remains the self, the doctor has the opportunity to add knowledge about the body, support the self of patient and allow a sense of reconciliation between the patients' selves and their own bodies (Brasher et al., 2006; Johnson et al., 2004; Gray, 2009; Harter & Bochner, 2009; Harter, 2009; Ryan & Butler, 1996; Charon, 2006; Charon, 2009). Obviously, as the doctor listens to the accounts of self, the doctor's values are implicated in the understanding and the evaluation of the patients' stories. However this is exactly what the understanding narrative encounter creates, the merging of explicit and implicit values told and silenced stories revealed as part of the doctor's and the patient's accounts.

As a doctor working at Columbia University as well as an expert in narrative medicine, Charon (2009) tells stories about her acknowledgment of patient's narrative in her practice and the powerful consequences of such an endeavor. She reports that after learning about the power of narratives in connection to the individual's self, she decided to start her visits by letting the patient know that she was interested in them as people first and their bodies second in order for

her to better care for them. Charon's opening statement is both an invitation for the patient to offer stories about self and a form of promise on her (provider's) part to receive the self of the patients, allowing for dialogue (Lipari, 2004).

Charon (2009) reports that in approximately the same amount of time spent during traditional visits, she had the privilege of meeting the patients. By listening to their stories, she was able to identify the patients' values and consequently determine the patients' needs and their fears and to recognize how those needs are unmet. She was able to listen to stories providing information on the origin of the patient's values and beliefs and to connect the dots and serve as an agent of reconciliation between the patients and their ill bodies. In one instance, after listening to her patient's stories, instead of prescribing an MRI as the first intervention, she prescribed an automatic wheel chair because she realized through the patient's story that he valued self-reliance and was not going to get out of his bed if his wife had to continue to pushing his wheel chair around. The MRI followed rather than preceded the purchase of an automatic wheel chair.

Besides patients' narrative, providers recalled stories in order to relate to their patients' experiences and create a sense of humanistic care (Charon, 2009). In a narrative exercise, Charon's medical students provided accounts of the patients who distressed them the most. As they were recounting the stories to other health providers, some of the medical students realized the extent to which they closely shared and almost entered the story told by their patients about their bodies as they suffered through the illness. The providers found themselves suffering along with patients and agonizing about their own emotional pathology, the incapacity to help the patient in need. The providers were able to relate the written experiences of their suffering to colleagues, but as they related the stories, it was the suffering providers themselves who were the ultimate destination of the stories rather than their listening colleagues (Charon, 2009).

Narrative as Performance

Narratives are mediated performances in which co-authorship bridges the gap between provider and patient, and they are also aesthetic performances that allow the health providers to use their imaginations to enter the world of the patients' suffering and share part of their lived experience. Because of the level of pain and helplessness of the patient, the provider looks for ways to relate to patients that are rather limited since the need is so overwhelming and the acuteness of the illness creates a desire for the provider to distance him or herself from the biomedical model and enter into a more humanistic approach. The aesthetic characteristic of narrative medicine is evident in the work of Charon (2009), who requires her medical students to write about their patients as they experience that illness. Such accounts necessitate that medical students use their imaginations in order to identify the patients' values and also understand their experiences by momentarily relinquishing personal health privileges. Such accounts reinforce the importance of dialogue as love and responsibility where the providers respond to the face of their patients using a self reflexive written exercise in the process of providing health (Kierkegaard, 1995; Levinas, 1996). The limitation of this method is that it is time consuming and emotionally intense. Also giving time and expression of emotion are usually not recommendations for providers in the biomedical model.

Narrative as a Co-Creation

Other uses of narrative medicine reveal the power of narratives as both mediated and dialogic and also as co-constructive endeavors (Harter, 2009). The dialogic and co-constructive characteristics of narrative medicine are revealed through practices such as those of Dr. Andersen. While he might not claim to use narrative medicine, he acknowledges the importance of storytelling for patients whose expectations and sense of hope are faltering. Andersen sits with

his patients in their room during hospital hours with the rest of the medical team, allowing the patient to realize that they (the doctors) care and are not too consumed with their work and can attend to the patient's need. The dialogic nature of narrative medicine suggests the indeterminate nature of stories because they are co-created by provider and patient. Andersen co-constructs calendars with his patients so that the patients take the leading role in the mapping of their lives using a calendar. He includes the creation of a page summary by the patient and the family members. Andersen believes that family members play a crucial role in the provision of health care for the patient. The calendar and the page summaries constitute some features of co-constructed stories and a dialogic performance between Andersen and his patient. The co-construction of stories also illustrates the provider's attempt at identifying the values within the patients' stories, choosing to understand and address them, and finally to help the patient utilize values as a resource for overcoming illness (Harter, 2009).

Narrative in Interaction

Cameroonian doctors and patients co-create (Sharf, 2009) new patient-provider communicative frames through their silence or voicing of each other during their interactions. Sharf suggests the idea of health providers as narrative "co-creators" (p. 136). She acknowledges the importance of a text in storytelling, text being the words or embodied part of the stories accounted and recounted by patients. However, she also proposes the use of pictures as legitimate and powerful tools in storytelling. Pictures help providers better understand the health issues, struggles or victories of all patients including the socially and economically disenfranchised. Such suggestions are valid but possibly not applicable to the one time encounter between the provider and the patient that often occurs. Besides, the emphasis on visual support as part of storytelling, Sharf argues that beyond merely sharing the experience of patients

through storytelling, health providers can more actively co-create new and redemptive stories so that patients can possibly envision their disabilities, illness or pain in a better and more empowering light. The process of co-creation may seem ambitious and possibly arrogant on the part of the provider who instead of bridging the gap existing between him/her and the patient, makes direct suggestions pertaining to the patient's body but also to the patient's self. However, when suggested by the patient, patient-provider co-creation of a new story can be both redemptive and healing for both patient and the provider (Airhihenbuwa, 1995; Cooper-Patrick et al., 1999). The idea would probably be to keep the patient at the center of the co-creation process (Sharf, 2009). The cultural Cameroonian context challenges the co-creation process because the patient tends to purposefully limit his or her participation in the exchange. The notion of co-creation in narrative medicine attests to the joint process taken by the health providers, the patient and the patient's loved ones in order to create new and redemptive narratives bringing healing or the hope of healing for the patient.

Besides the co-creation of narratives, Langellier (2009) suggests that the performative side of narrative medicine should be extended and transformed in order to bridge the existing gap between providers and patients. Langellier (2009) notes that to understand narrative medicine as performance is to recognize bodies as texts and recognize stories and selves as internal to the practice of medicine and the caring for the ill. The body of the patient and the body of the health provider participate in the performance and telling of the story of the patient provider encounter; however, simultaneously each body illustrates and performs an embodied story. She notes, "Binding narrative medicine to performance marks it as both embodied and discursive, a site where vulnerable bodies are textualized as stories" (p. 151). This is an ideal that may be difficult to achieve in the Cameroonian health context. What can occur is that providers and patients can

be attentive to the role of narrative and use it as part of their interaction and dialogue with one another, a move toward greater narrative competence.

In narrative medicine, health providers, patients and sometimes patients' family members co-construct stories performatively through the gestures of hands, adopted postures, eye movement, use of voice and other bodily techniques of communication that help to express or conceal, show compassion or avoid, come close or remain distant. Therefore narrative competence depends on the individual's performance of the narrative during the interaction between providers and patients. As such stereophonic listening challenges providers to use voice in order to open heartedly and to help co-construct the reality of illness with the patient (Langelier, 2009).

Stereophonic listening or listening out loud does not transcribe a person's account, instead it requires the listener to receive the story of the other and retell the story by experiencing it in his or her own body. In the Cameroonian context, listening out loud suggests that health providers would take the time to listen, that is, to receive the stories of the patients, seeking to understand the story from the perspective of the patient, and then to repeat the story out loud using tone of voice and imagination to perform and co-create the patient's story of their illness (Langelier, 2009).

The chasm existing between providers and patients in developing countries is widened by educational and financial gaps that further challenge caring exchanges. The performative opportunity offered by "narrative medicine reminds us of that somebody has been hurt and that somebody speaks and gestures, touches and is touched, feels fear and pain, hope and despair"(Langelier, 2009, p. 151). Human beings in the context of health care providers can use

this reminder to grow closer to the ill person by participating in the performance of the person's health story.

Vulnerability in Dialogue

The concept of narrative medicine is a process that requires patients and providers to tell and listen to stories bridging the gap between them and growing closer to a dialogic encounter, a form of metaphysical closeness. However this process becomes dialogic as patients and providers choose to be vulnerable, that is, to open during the encounter. Suffering and the vulnerability derived from it punctuate performance in narrative medicine. During the encounter both patient and doctor can relate to pain; however, the choice to admit one's vulnerability to and through the story of illness is a choice that doctors and patients can make during the health encounters. The choice to admit to one's vulnerability and desire for healing through storytelling is a choice that can take both the patient and the health provider through the healing process from present and past wounds inflicted by illness, injury and or death. Zaner (2009), a practitioner in health care, noted "I too needed someone to listen to my own transforming as I learned to tell their [patients'] stories, as I listened and lived within the settings of illness and injury"(p. 175). Besides their personal curative power, when providers choose to make themselves vulnerable to patients, stories also enable them to practice humanistic care that embodies the values of the practitioner and patient. The use of vulnerability in storytelling facilitates the practice of communal, humanistic culturally relevant values for providers and patients, and it provides a great avenue for providers and patients to metaphysically connect as vulnerability sets the atmosphere for their dialogue.

Caregivers that allow themselves to become vulnerable to patients' stories gain the trust of patients leading to healing and/or better coping strategies (Zaner, 2009). Trust is a critical

element in the relationship between providers and patients that results in openness and disclosure. Patients' and patients' family members are part of various social networks including religious organizations. As Zaner's account illustrates, religious leaders' approaches to illness and death can have a great influence on patients and/or patients' guardians who attend their church. In this case the comments of religious leaders and congregation members lead the guardians to question the devotion of health providers to their patient. In listening to the guardians' story and in opening himself to the stories' cleansing work, Zane articulated the pain experienced by the guardians–the helplessness of the patients' guardian in the face of tragedy. In narrative medicine, the vulnerability of the provider to the story of helpless patients or family survivors is cleansing and helpful in not only establishing the bond of trust between the provider and the patient or patient's family and also in acknowledging personal injuries in need of healing.

Listening in Dialogue

In narrative medicine, the decision to listen to the patient's story and the building of trust is facilitated by the doctor's vulnerability (Zaner, 2009). The doctor stops being a god to be worshiped and becomes human with feelings and emotions, refusing "to shut himself off from himself"(p. 160). The training of medical students suggests that acquisition and application of technical knowledge makes a great physician (Conrad 1988); however, narrative medicine suggests that such knowledge is not enough to make a good care giver (Bochner, 2009). If doctors are unable to recognize their humanity in caring for other humans, and if they fail to acknowledge their emotional and visceral response in the process of providing health, then the health of the patient-provider relationship is threatened.

The relationship between the provider and the patient is an important health issue in narrative medicine because it acknowledges the context in which the provision of care takes place, just as dialogue does (Charon, 2009; Bochner, 2009). However, medicine and medical education require a paradigm shift in order to look at patient-provider encounters as processes in need of health-mechanisms whose stories need to be heard and retold. In the new story of narrative medicine and dialogue, the doctors get acquainted with the sick person in order to better know themselves, and the patients also get a chance to examine the providers. Therefore, narrative medicine conceives the patient-provider interactions as dialogic encounters where the provider and the patient engage authentically, acknowledging their feelings in hearing and listening to stories told and recounted. Bochner (2009) argues for an embrace of the vulnerability of medicine with its emotionality, subjectivity and humanity. Qualities of these forms of dialogic encounters coincide with some of the religious beliefs of Cameroonians.

Capacity for Dialogue

Acknowledging the need for emotional capacity in the practice of narrative medicine, some scholars (Thompson, 2009) express their concern about the applicability of such an approach. Thompson notes, for example, that some physicians do not have the emotional capacity to see what is not stated during the encounter with the patient. She provides the example of a medical student who was unable to learn the emotional and interpretive skill required in narrative medicine even after correction and advice. After much observation, Thompson realized that despite his effort the medical student was unable to show narrative competence or understand what transpired in the patient-provider dialogue. Thus, she argues for the inclusion of narrative and what I call dialogic ethics in the medical curriculum. Dialogic ethics allows physicians or other providers challenged by narrative ethics to learn health care principles and

learn to apply them in specific instances. The specificity in narrative and dialogic ethics has the potential to help providers who lack the emotional capacity to communicate sensitivity and compassion to patients, to learn new skills that will allow them to become better communicators.

Equality

Some of the principles that providers can apply to the relationship with patients are the notion of equality, which Rawlins (2009) emphasizes in the form of medical friendships based on dialogic ethics. Rawlins notes that friendships can develop as critical dimensions of primary relations such as the provider and patient, and these friendships allow the providers to perceive the patient's body and self in the context of that sick person's life. The contextualization of the patient's suffering helps the provider to appropriately and effectively respond to the patient; this in turn builds trust and trustworthiness in the relationships between doctors and patients.

Distance

Nevertheless, Rawlins (2009) also notes the importance of a certain distance between the patient and the health provider to ensure better appraisal of the health situation. He suggests that "empathetic distance serves the freedom of civic friendship" (p. 172). In his approach to narrative medicine, Rawlins recognizes the importance of storytelling and dialogic ethics in facilitating the development of friendship. He also views medical friendships as unique opportunities to know patients' suffering in their proper context; however, he also emphasizes the importance of some distance for the best medical practice. For health providers whose emotional capacity is limited, the principal of equality in the context of medical civic friendship as well as the need to maintain some distance might be more applicable than Bochner's (2009) appeal to vulnerability. Cameroonian health providers trained in cultural context where

emotional capacity is not valued, might find Rawlin's critic of narrative medicine relevant to their practice.

Narrative as a way of communicating is quite familiar to the traditional Cameroonian culture. Within the context of traditional Cameroon, various social activities are constructed, maintained and abandoned through storytelling. Traditional health care is one of those social sectors that naturally constitute a site for storytelling when the diviner recounts the circumstances pertaining to someone's bewitchment or death as well as the patients recount reasons behind their need for physical protection or material possessions. While storytelling plays a major role in African traditional health care, I am reluctant to claim that its role is often understood by those in Cameroon. However, I believe narrative medicine is performed using dialogue, as narrative and dialogue are practiced in medical interactions across cultural contexts.

Dialogue and Communication Ethics

The appropriate practice of communication requires the observance of a certain ethic of communication. In a cultural context in which history, world view and economical pressures combine to constrain provider and patient interactions, the attention to ethics in communication constitutes a transcendental map for the patients' and providers' interactions. Ethics of dialogue or the verbal interchange between individuals has developed around several concepts. Some of the concepts of ethical dialogue that are especially relevant to African Christianity and Native religion include dialogue as responsibility and embeddedness.

Dialogue as Responsibility

In contemporary religious communication ethics, some Cameroonian leaders suggest the need for communion while caring for others (Mamia & Massaga, 1999). The leaders emphasize the need for humans to adopt an attitude of communion, a spiritual uniting of people, while

relating to each other, so that they can reach one another beyond the mere deed of kindness. For providers to enter the metaphysical realm of communion and address their patients' needs, they have to recognize the metaphysical face of the patient calling to them and be responsible to that face of the other.

Levinas and the Other

Levinas' (1996) conceptualization of ethics in dialogue starts with the notion of responsibility. The self does not start to be until he or she has answered the call of the other. Levinas' approach to subjectivity counters the "Western" notion of being where the self is concerned with self-expression and the need to be for his or her own actualization, ignoring the need to reach the other at a transcendental level. By other, Levinas refers to all who are other than one's self. In his explanation of responsibility, Levinas specifies that the relationship between the self and the other is an asymmetrical relationship. Thus, the self cannot expect anything from the other, while answering the call of the other's face. This concept emphasizes a spiritual demand on humans from someone who is different or other. Levinas' notion of responsibility towards the other involves the concept of the "saying" and the "said," communication concepts that are important elements of the phenomenal encounter of the I and the other (Levinas, 1996; Murray, 2007, p. 39).

Levinas (1996) defines the saying as the proximity between the self and the other, while the said is the linguistic or expressive communication most associated with self. Levinas notes that the saying occurs before the said. The saying occurs as the self receives the call from the face, the face being abstract, transcending features and other common facial characteristics (Murray, 2007). In the context of biomedical health care, the health provider tends to respond to the said; however, Levinas claims a response to the saying located beyond the linguistic

expression of the patients (Bochner, 2009); for example it is a spiritual command, even though the Cameroonian patient might look composed and nonreactive to a provider's expensive prescription, it is important for the provider to acknowledge the metaphysical face of the patient that cries out for consideration of his or her financial health condition and situation.

Lipari and listening. Extending the concept of the saying and the said, Lipari (2004) introduces the notion of listening and the heard. In her explanation of these concepts, Lipari suggests that the process of hearing occurs as the self uses personal judgment and categorical knowledge in order to understand the other. The heard is a demonstration of the self's desire to control the encounter. Listening occurs as the self retracts in order to allow the other and receive him or her. As one listens, the individual acknowledges his or her own judgment and chooses to suspend it in order to receive the other, using the other's understanding of the world in order to receive him or her. It is this unique conceptualization of listening that creates ethical dialogue between providers and patients.

The concepts of the saying, the said, the heard and listening have significant application within the context of interpersonal interactions between provider and patient. While a health provider can be well intended in his or her attempt to respond to the call of his or her patient, if the patient is merely heard, there is a possibility that the provider might respond inappropriately to the patient. It is important for the provider to use listening, that is, to consciously suspend judgment and other forms of categorical knowledge in order to reach for the patient. This is more applicable to the Cameroonian context where some patients come from the rural areas where traditional medicine is commonly practiced. The doctor may miss the call to attend to the face of the other when he uses only biomedical knowledge and does not recognize Native beliefs or practices of Native healers (Lipari 2004).

Arnett and Dialogic Ethics

Arnett (2001), a communication scholar, draws on philosophy for his theory of dialogic ethics. Levinas' (1996) conceptualization of ethics, which relies on the categorical call to responsibility towards the other in an asymmetrical relationship, differs from a variety of scholars who explain dialogue as the basis of communication ethics (Arnett 2001; Buber, 1966; Johannesen, 2000). Unlike Levinas who emphasizes relational asymmetry, Buber discusses the relationship between the "I" and the "Thou" as intersubjective. In the dialogic encounter while the self reaches for the other, the response of the other is not a necessity, yet it is a possibility. As the self reaches for the other, the other might respond to the self. This relates to Buber's concept of the in between, which is the place where the other and the self merge. According to Levinas (1996), the expectation of any response from the other is self-centered because it causes the self to expect when the act of responsibility must be totally centered on alterity. Buber argues that to deny the potential of a response is to deny part of the other, that is, the other's response.

Following Buber (1966), Arnett (2001) conceptualizes dialogue as an intersubjective encounter where the response from the other is necessary in order to create civil dialogue. However, Arnett (2001) adds a new dimension of context. According to Arnett, it is important to realize that each one speaks from a specific standpoint, this is to say, the other's voice is located within a specific historical context which influences the other's agency. To ignore the fact that the other's agency is constrained by context might hinder the subject's ability to be responsible and respectfully respond to the other person in interaction.

Embeddedness. As part of the debate on dialogic philosophy, Arnett (2001) brings the notion of dialogic civility. It offers an extension to the existing prioritization of the other, by adding the notion of listening to the other in historical context, and acknowledging the others'

dialogic freedom. Dialogic civility relates to the Cameroonian patient-provider dialogue, which has moved from the traditional health care to Westernized health care context. The position of the patient and the provider during the communicative act as well as the history of traditional patient-provider communication must be acknowledged, but this does not always occur in Cameroon.

Arnett (2001) introduces dialogic civility as "a metaphor that is part of a philosophical conversation between action and agent" (p. 315). He starts by contextualizing the dialogic communicative background within the context of biases and interpersonal restraints that must be acknowledged in order to hear and consider the other. Thus, application of dialogic civility in Cameroon suggests that health providers and patients cannot adequately enter into dialogue unless health providers understand the traditional and historical restraints faced by patients from pre- to post-colonial times.

Situatedness. For dialogic civility to occur Arnett (2001) identifies several conditions, one of them is the situatedness of objectivism as well as the flexibility of relativism. Objectivism is a perfect assurance in what one is seeing and saying, and relativism is a contextual understanding of what is true. The need for relativism stems from the notion of alterity (the other) and the historical situations embedded in the interactions. Significant choice could be used as an example to demonstrate the dependency of choice upon the historical and cultural practices. The Western biomedical training of some health providers imposes clear limits to providers regarding their flexibility of relativism; yet, according to Arnett (2001), the need for the individual to understand what is true relates to patients and their contextual realities.

Civility. Arnett (2001) emphasizes the fact that the discourse starts with the other. Therefore dialogic civility opposes conversation centered upon the self and calls for an

environment where various ideas are respected. Such environments make room for narrative disagreement, where people holding different metanarratives and ideas about how the world should be can come into an interpersonal context and acknowledge the other and his or her embedded agency. This is true for Cameroonian doctors, who often operate within the Westernized health care metanarratives that relies on scientific knowledge, even though their patients are speaking from indigenous Cameroonian metanarratives that rely heavily on metaphysical power (Rosny, 1985). The subject must recognize the other's response within the others' historical and cultural constraints.

Besides the boundaries of dialogic civility, it is important to understand the notion of civility, which implies the presence of diverse voices brought together to enter a public conversation. Such an endeavor requires the disciplining of one's voice to allow others to be heard. In order to respect the other, it is wise to have both a foreground and a background understanding for the actions performed during the communicative exchange. Merely foreground interpretation of a patient's behavior keeps the doctor from truly understanding and respecting the patient as the other. For example, deeming a low income female patient negligent for going back to work in the fields two weeks after a hernia surgery is only foreground interpretation. Seeking background understanding through further dialogue with the patient might show that her whole family's survival depends on whether or not she goes to the field every day. Thus resting for more than 14 days is not an option. Having the necessary background information on the other and engaging in a deeper analysis of the socio-cultural reasoning behind their actions makes for a better case for dialogic civility (Arnett, 2001). By asking questions and listening for the patient (Lipari, 2004), the provider gains background understanding of the patients' situation, locating the patient's voice in the proper context.

As part of dialogic civility, Arnett (2001) recommends praxis or theory-informed action. The action is informed by the theory resulting from the civil conversations. In cases of less mutually understood communicative occurrences, the co-construction of background "thick" descriptions facilitates and guides the basis for praxis. Because provider and patients often come from different socio-economic as well as ethnic background, the use of "thick"(p.333) descriptions is important for providers as well as patients to better understand the background which surrounds the other's communication. Thus, to Levinas' notion of responsibility to the other and Buber's allowance of the other's response, Arnett's adds the contextualization of the other's response through the disciplining of the self as well as the subject's well informed and practical response to the call of the other. This might be an idealized theory for patient-provider interaction, but it does identify communication practices that promote humanistic care.

Summary

In summary, the general description of Cameroon provide an understanding of the socio-economical challenges faced by Cameroonians as well as health providers' discontent and reluctance in practicing health care especially in rural areas. Looking closely at providers' and patients' belief about health, existing literature suggests that professional providers' Westernized approach to health is biomedical and relies on disease treatment while traditional approaches to health are often inclusive of holistic care, based on various religious beliefs. Further exploration of local religious beliefs reveals that Christianity and Native religion are the main religious practices that influence Cameroonians' life and their preferred approach to health care. Whether Christian or Native believers, Cameroonians look for explanation and empowerment from religion. For some Christian religious leaders, Christianity is the opportunity to transcend the fear of the other to open to communion with the other. Within the context of patient-provider

interaction, opportunities to practice communion in interactions challenge the biomedical training of providers. Suggestions to allow such heartfelt communion come from narrative medicine through storytelling and performing, so that both providers and patients can bridge the existing gap to become one. Communication ethics provided further concepts relevant to the local system under the form of responsibility and embeddedness to reinforce the selflessness of this attempt to communion as well as the need for acknowledgement of the other in their cultural and unique position.

In this chapter, I (1) provide a general description of Cameroon; (2) explore biomedical as well as holistic approaches to health and describe the Christian and Native religious context in which they thrive; (3) discuss patient-provider interaction as the micro-context in which health beliefs are manifest; and (4) describe narrative communication practices and dialogical ethics in order to explain communicative encounters in Cameroon.

Methods of data collection and analysis will be explained in the next chapter. The choices of data and methods discussed in the next chapter stem from the details related in the review of literature as well as the questions that guided the study. The limited amount of research done in communication and health in Cameroon, and the literary evidence pointing to the importance of African religiosity, suggest an examination of the existing relationship between providers and patients in terms of Cameroonian's conceptualizations of health, the influence of Christianity and Native religion, as well as the role of communication in the patient-provider encounter. Specifically, I purpose to look for answers to the following questions:

RQ1: How do the assumptions of the Western medical model intersect with those of the native culture in patient-provider interactions?

RQ2: How do Cameroonian providers and patients conceptualize health and illness?

RQ3: How does Cameroonian culture, especially Native and Christian religious beliefs, influence the beliefs and practices of provider and patients?

RQ4: In what ways do the interactions between providers and patients incorporate narrative and dialogue?

RQ5: What are the differences between how providers and patients view the quality or ethical aspects of the health related interactions they have with each other?

CHAPTER 3: METHODS

The review of literature on health beliefs, communication practices and religion in the Sub-Saharan context informed the choice of methodology used in the present study. Considering the fact that limited research has been done in health communication within the Cameroonian context, in depth interviews were used to gather data and a thorough thematic analysis was used for interpreting the data. The present chapter: (1) restates the goal and research questions; (2) explains the role and identity of the researcher; (3) describes the field interview process; (4) describes the assumptions of the interview process; (5) identifies the interview procedures in terms of arrangements and questions asked; and (6) explains how I analyzed the data.

Goal and Research Questions

In the present study, I explore how providers and patients conceptualize health beliefs, how the cultural context in Cameroon influences health, how providers and patients perceive interactions with one another, and how communication practices impede and enable effective patient-provider interaction. My literature review generated the following questions for my dissertation research:

RQ1: How do the assumptions of the Western medical model intersect with those of the Native culture in patient-provider interactions?

RQ2: How do Cameroonian providers and patients conceptualize health and illness?

RQ3: How does Cameroonian culture, especially Native and Christian religious beliefs, influence the beliefs and practices of providers and patients?

RQ4: In what ways do the interactions between providers and patients incorporate narrative and dialogue?

RQ5: What are the differences between how providers and patients view the quality or ethical aspects of the health related interactions they have with each other?

Rationale for Conducting a Qualitative Study

Although most of the health communication research done in the U.S. uses quantitative research methods, I decided that qualitative methods was the best approach to find answers to the questions that evolved from my literature review. Several reasons lead me to conduct a qualitative study. First, my study of health interactions takes place in Cameroon, a context where no research has been conducted on patient-provider interactions. I recognized that I needed to figure out what provider and patient beliefs and practices are before I drew any conclusions about how the Western medical model relates to these types of interactions. Second, since I grew up in Cameroon, I knew from experience that Native and Christian religious beliefs often are syncretic, that is, syncretized and merged together as part of one's articulated and subconscious beliefs. Moreover I expected from my own experience that these religious beliefs are somehow connected to health beliefs, but I did not know the specific connections. Field interviews could provide some of this missing information. Third, existing anthropological research acknowledges the role of Native and Christian religious beliefs with Cameroonian culture, but it does not deal with the impact of these religious beliefs on health interactions in general or health communication practices in particular. Fourth, studies of culture often use an ethnographic approach so that the researcher can use the voices of participants to understand a culture from the points of view of insiders in that culture. Finally, my study of several scholars who write about qualitative and quantitative methods insist that the questions drive the method, rather than the method driving the questions. My research questions could not be addressed without conducting field interviews since I wanted to include my participants' own conceptualizations of religious

and health beliefs, patient-provider interactions, and the quality of communication within those interactions. The qualitative method of interviewing and participant observation allowed me to understand my study participants' conceptualization of health, interaction and communication from insiders' view point.

Role of the Researcher

Within the context of qualitative research, the role of the researcher is critical in the collection of data, the choice of relevant findings and their interpretation. Considering the fact that the present research involved in depth field interviews and some field observations to support the interview data, I needed to be aware of my subjectivity in the process of collecting and managing data.

As a native Cameroonian woman and part of a relatively large health campaign team, I did not physically stand out during the process of observational research. However, to make sure that my note taking did not raise some questions in the mind of the patients waiting or talking to their doctors, I used discretion. No patients seemed curious and uncomfortable with my behavior. If this had been the case, I would have approached them first and then given them information on the research. As I collected data through observation, I was careful to remain self-reflexive, by analyzing and questioning the motives behind the choice to record specific scenes or activities.

The process of interviewing, since it involves interpersonal interaction, is also subject to my bias and influence. Therefore during the interviews, I practiced dialogical ethics by acknowledging the participants and giving them time and room to share part of themselves, while absorbing the information and taking notes (Lipari, 2004, Charon, 2009; Lindlof & Taylor, 2002). During the interviews, the participants in my study had the opportunity to tell their stories

as well as ask me questions; questions that helped both participants in the interview process work together and create new meanings (Sharf, 2009).

Besides the data collection process, the analysis of the data was another aspect of the research project in which my role was highly influential. Since I selected the elements of focus and suggested lenses for interpretation; both of these research activities inherently influenced my understanding of the findings (Lindlof & Taylor, 2002). In acknowledgement of the high level of influence that the researcher holds, I chose a data-driven approach for analysis in which my research findings were derived from the data. Furthermore, to facilitate the reading of research findings, it was important for me to also articulate my cultural identity and position.

I was born and raised in Cameroon by a Cameroonian father from the Bassa tribe and a Caribbean mother from the island of Saint-Kristopher and Nevis. While my mother did everything that was in her capacity to expose us to Kittitian culture, I drew a considerable amount of my values from the Cameroonian context. Despite his strong attachment to the Cameroonian culture, my father never presented traditional healing practices as an option. When we were sick, my father would get educated about our illness and attempt to take care of us by himself, and if he saw no improvement then he would take us to the hospital to receive care from a western trained medical doctor.

According to Cameroonian standards, both my mother and father are highly educated and they are both Christians. Therefore, from a young age I learned to prize education, explain illness using scientific knowledge, and understand my body and how it worked with the help of a western trained medical doctor. I was also taught to believe in God and pray for his favor instead of believing in the power of traditional healers. Interestingly, the rest of my family members often shared narratives about the power of traditional healing, and close acquaintances including

my house nanny believed in traditional healing. Despite the fact that I did not embrace the practices of traditional medicine, I was fully immersed in the philosophical and cultural paradigm in which traditional medicine was discussed and adopted by those in my community. As I became an adult, I gained further understanding pertaining to the philosophy behind traditional medicine and its practice. However, I also deepened my understanding of Christianity and my personal relationship with Christ. Thus, my Christian values remain today, and they have given me a better appreciation and understanding of the traditional spiritual world.

In comparison with the average adult in Cameroon, I would be considered highly educated, a factor that is usually associated with frustration and intolerance of traditional ways and lack of respect for the Native religious beliefs. Whether or not I identify with these descriptions, it is important to note that traditional Cameroonians often ascribe these attributes to highly educated individuals. By acknowledging these ascriptions, I needed to clarify for my participants my desire to acknowledge and value their experiences and better understand their perspectives as Christians, as practitioners of Native religious beliefs and as people that share a common cultural heritage with me (Lindlof & Taylor, 2002).

This acknowledgement of my cultural background in terms of religious beliefs as well as my educational and upbringing constitute important elements of my self-reflexive process. As a Christian and a highly educated woman, I have to purposely remain aware of my positioning, suspend value judgments that may derive from my different cultural identities and appropriately receive the valuable information gathered through this research process.

Field Interview Process

In order to adequately guide my interview process, I created an interview protocol (Appendix B & C) including interview questions that would provide answers to general health

research questions. In order to address the question related to the effects of culture on perceptions of health, I asked open-ended questions such as: "When does a doctor behave in a culturally inappropriate way? Can you recall a story of an encounter with a doctor who behaved really inappropriately?" To answer the question related to patients' and providers' conceptualizations of health, I asked open-ended questions such as: "Please finish the following statement (using a story to elaborate) I feel healthy when…." To address the question related to the influence of religion on health beliefs, I included questions such as: "What links do you see between your health and your religious beliefs?" In order to investigate features of dialogue in patient-provider interactions, I asked questions such as: "How can you tell that a doctor cares about you? Or can patients tell that you care about them? Can you think about a story to illustrate the point? " Finally, I prompted answers and emotional reactions and follow up comments using questions such as: "When does a doctor/patient behave in a culturally inappropriate way? Can you recall and tell a story of an encounter with a doctor/patient who behaved really inappropriately?" These questions provided answers for the research question related to differences in providers' and patients' views of the quality of their health interactions. While the use of an interview protocol helped guide my communicative exchange with participants, I also gave them the opportunity to spend more time discussing issues that they felt were pertinent to them.

Description and Selection of the Participants

The participants, patients and doctors, involved in this research project were French and English speaking Cameroonians. Within the context of this study, Cameroonians are individuals who either were born in Cameroon or have lived in Cameroon for over ten years. Cameroonian participants were both residents of cities and residents who lived or worked in smaller towns or

villages (refer to Appendix D for participants' profiles). Villages are rural communities with limited community support and health care options. Some villages have western health care facilities in the form of small health centers; however, the facilities usually have only a doctor or two for the entire village and the rest of the health care providers are nurses and health care assistants. Villagers often retain African traditional lifestyles, including home and herbal remedies for sickness, as well as other forms of natural health care treatments. The means of transportation to other communities are scarce and basic necessities such as running water and electricity are privileges. Cities with larger communities have more infrastructure then rural areas do, both economically and in terms of health care systems. The biggest hospitals are located in Yaounde and Douala, the political and economical centers of the country, and patients in need of the most delicate and specialized care are usually sent to the public hospitals in these capital cities.

Whether villagers or city dwellers, most Cameroonians value community and family (Moemeka, 1996). This means that as people from other parts of Africa, Cameroonians identify strongly with their communities, see their community as an important source of support, and show a personal sense of responsibility towards the community. With the acute financial crisis (Leonard, 2009), it has become difficult for people to continue to care for other members of the community (Hell & Hell, 2011). Thus, communalistic behaviors such as offering food to strangers, disciplining neighbors' children, or offering social support to strangers in a taxi have become less common; however, people continue to uphold and value family and community support as ideals.

Christian and Native religions are also part of both the rural and the urban system. While rural settings tend to show greater connection to the traditional life style, including Native

religious practices, most villages also include Christian religious communities whether Catholic or Protestant. The modernized urban areas are relatively open to the Western life style and beliefs. However, along the streets of the capital city, one can see multiple signs advertising the services of traditional healers and sorcerers that work alongside modern health providers. Therefore the recruitment of participants from rural settings and more urban settings provides a more complete picture in terms of the health communication needs of Cameroonian citizens.

Sampling

The form of sampling used for the project was a kind of snowball sampling. As Lindlof and Taylor (2002) suggest snowball sampling is particularly relevant to interview studies. This form of sampling process is relevant when seeking to engage people on a sensitive topic like the one discussed in this study or to deal with sensitive populations. While Christian religion is legal and openly discussed in Cameroon, within a highly Westernized context such as mainstream health care some doctors find it difficult to discuss their religious views. Also, after colonization certain Native religious practices have become secretive and taboo, giving a stigma to Native religion. Therefore, the use of snowball sampling allowed for referrals from participants who became a type of "research assistants" (p. 124).

The sampling process of patients started with community leaders' announcement of the projects in Yaounde, one of the capital cities. The announcement was supported by a visit of the researcher to the religious groups, as a cultural form of respect towards the prospective interview participants, who needed to see the face of the one calling the other in the interviews. Following the announcement, the sampling process evolved into self selection so that members of the congregations contacted me individually in order to schedule a meeting. The sampling process for doctors was made through doctors' referrals. Thus, doctors currently practicing in one of the

public hospitals of the two capital cities (Douala and Yaounde) or in a private hospital (Douala and Yaounde) informed other doctors of the research project. The doctors who expressed interest met with me, and together we made a decision about the interview and planned for a meeting time and place.

Snowball sampling was also used through designated individuals who served as points of access. The congregational leaders as well as the lead doctors facilitated the snowball sampling process. As head and part of these communities, these individuals were able to present the messages to their communities in a way that not only made sense but also ensured trustworthiness and protected interview participants.

I met privately with one of the Christian religious leaders in order to further explain the purpose of my project and the need for participants who would be willing to share their experiences as Cameroonian patients. During one of the congregational church conferences, the leader announced the project and asked people who needed more information about the project to provide me with their contact information. After the congregational activities, members of the church who were interested in knowing more about the project provided me with their contact information. Because of the method of payment for cell phone calls (reception of calls is free but calling is not) and for practical measures, I agreed to contact prospective participants using the information they had given me. During these calls, we further discussed the purpose of the project. I clearly explained that the initial phone call was not binding, and they could still refrain from joining the research project. Some of the congregational members took that liberty. However, others set appointments with me, and they chose the venue for the interview.

To recruit health providers, I met with a doctor that I got to know through a family member and after giving him details about the project he offered to talk about the project with

his colleagues. Once the colleague had been contacted, and they agreed to have a meeting with me, I went to their offices and further explained the purpose of the study. If the provider was willing to proceed, we made the necessary arrangement for an interview.

The gathering of data through in depth and narrative interviews (Lindlof & Taylor, 2002) is a rewarding process, which provides the researcher with exclusive information about the researched population that other forms of research methodologies overlook. However, depending on the nature of the researched phenomena, there comes a point where the information gathered from one interview to the other becomes repetitive so that the stories of the interviewees seem to render the same information. Once such repetition was observed, I recognized that I had reached the point of saturation. At this point, the information I gathered from interviewees was no longer new and I stopped the investigation. Therefore, I continued interviews with patients and doctors until the point of saturation was reached for both populations. I conducted 30 interviews.

Protection

The nature of the sampling process required some measures of protection for the participants (refer to Appendix A for IRB protocol). In view of the fact that prospective participants were initially introduced to the project by individuals in positions of power, the prospective participants could have felt obliged to participate in the study in order to gain favor from their congregational leader. I found individuals from the Christian religious group that were willing to participate in the project and let them know that they were required to contact me individually without the involvement of their leader. For the health providers' interviews in public hospitals, the local health care protocol required that the doctor who was my point of contact to introduce me to health providers who showed interest in my research project. Because the doctor recruiting his colleagues was young and in no specific leadership position, prospective

participants were free to join or withdraw from the project; some doctors did withdraw from my interviewing process. My meetings with the interviewees were generally private and preferably at a location of the interview participant's choice.

Doctors who participated in the study requested their meetings be in their offices. For the most part, the door of the office was closed for privacy, and the participants took a break from their work. The offices were private and familiar enough for the health providers to disclose information at ease. The office was also a quiet and interpersonal space appropriate to build rapport and engage in focused dialogue. Because of the private setting and the quality of the dialogue, doctors seemed open and relaxed. However, because I conducted the interviews at their work places, narratives and expectations from the scientific culture were more salient than they might have been otherwise. Considering the key purpose of my study is to gauge the influence of cultural assumptions on health, the provisions of health, and patient and provider interactions, interviewing doctors while they were immersed in their scientific cultural habitat seemed an appropriate place for gathering information.

Patients that participated in the study chose a variety of venues for interviews. Most male patient interviewees preferred to meet in public settings preferably close to the church. I came to realize that this preference was probably related to the cultural rules surrounding gender relationships in Cameroon. It would have been culturally inappropriate for the male participants to welcome me into their family homes as a newly acquainted female. However, the meetings that took place in the church vicinity were conducted in private during week days when no church services were taking place. Thus, patients were open and comfortable, providing me with rich and nuanced accounts of controversial encounters with providers, including providers of spiritual health. Patients that invited me to their homes were all female participants; however, I

did not see any particular differences in level of comfort or disclosure between the participants who welcomed me into their homes and those whom I interviewed in more public venues. I put a great emphasis on rapport building before and during my interviews so that patients were as comfortable and trusting as they would be if they shared this kind of information with a close friend.

I gave participants who were uncomfortable with the idea of being interviewed alone the option of disclosing their intent to participate in the project with a close family member that they could choose to bring during the interview meetings with them. I told prospective participants that their identity will remain confidential and their names and locale will be replaced with pseudonyms. However, I also told them that they had the option to terminate their participation in the study at any time.

Participants who requested meetings at their homes did in fact have family members present during interviews, mainly because of communal cultural norms and availability of meeting space, but this did not appear to alter their level of disclosure or comfort. As mentioned previously, some participants provided their contact information, but later expressed their desire to withdraw from the project for personal reasons. I reassured the participants who told me about their inability to participate, reminding them that refusal to participate was confidential and as far as I knew it would not result in any loss of privileges. I perceived non-participation as positive evidence that prospective participants did not feel pressured to be part of the project.

In order to have a general and nuanced understanding of accounts from my patients, I also observed and made concise field notes of patient-provider encounters, especially in the rural settings. The rural health care context was a part of a private health campaign initiative to help patients with extremely low socio-economic status and acute illnesses. During these

observations, I watched patients' interactions while waiting for providers, as well as patients' interaction during consultations. I was looking for support or contradictions with the accounts collected during interviews. The first venue observed took place in a covered courtyard with shade where adult patients and children were offered free medicine for treatment of stomach parasites. The second venue for observation was a room where three booths were set up for consultations, one for examination and another as a waiting area. Consultations occurred simultaneously in the three booths, each one with a doctor conducting the consultation with assistants.

Assumptions of the Interview Process

The ontological assumptions that guide qualitative research are well suited to the context of communal cultures (Moemeka, 1996). The ontological assumptions that guide the qualitative research suggest that reality is socially constructed and that therefore during the process of communication, individuals create their reality. In cultures that tend to be communal, such as the Cameroonian culture, reality is created and recreated in the process of interviewing, sharing stories, and dialogically interpreting them. The interview process thus constitutes a familiar occurrence in which the participants communicate through oral stories familiar to their cultural traditions and allow me to enter into a process of co-creation with them in which their meaning is shared with me. The process of co-creation of reality involving the investigator and the participants allows for a greater sense of shared meaning and deeper understanding of the participants' reality in patient-provider encounters within the Cameroonian context.

While conducting research interviews in cultures where some forms of knowledge are taboo and can only be discussed within the context of meaningful relationships, the use of qualitative research is deemed relevant. Thus, I approached the researched dialogically (Lindlof

& Taylor, 2002; Lipari, 2004); that is, by retracting myself and listening, by suspending personal categorical knowledge, and by using the cultural knowledge to record and interpret information. The use of a dialogical form during the interviews allowed more room for the participants to finally voice their stories concerning patient-provider interactions without the fear of being judged or rejected by me or others for sharing their accounts.

Interview Procedures and Questions

Of the 30 interviews, 29 were recorded using an electronic recorder, and one was recorded partially in writing. As Lindlof and Taylor (2002) note the beauty of recording devices is that "they capture the interview more or less exactly as it was spoken" (p. 187). The use of electronic recording allowed me to record nonverbal details such as voice quality due to emotional reactions and hesitations as well as personal reactions to the interviewee's comment. All of these details gave me critical insight in selecting important scenes and identifying significant issues raised by interview participants. Personally, I was able to notice communicative elements that are helpful for the interviewer to engage in rich and rapport building interactions.

During the interviews, the recorder was always placed in plain view; before using the device, I reminded the participants that the interview was going to be recorded. Some participants joked about having their voices put on tape and their need to be official. However, I reminded them that I was the only one who would hear the recording before transcription, and once transcribed, their interviews would no longer bare their identity, after which participants who at first seemed slightly nervous no longer paid attention to the device. Also, I made sure to check and prepare the device ahead of time (battery loading) so that I would not need to draw more attention than necessary to it during the interview (Lindlof & Taylor, 2002).

Observations were recorded using field notes. Field notes are shorthand reconstructions about an occurrence, and these raw notes are only available to the researcher (Lindlof & Taylor, 2002). I took field notes while I was participating as part of the health team and while sitting by one of the campaign booths. Because I had official permission from the leaders to observe their health campaign practices, I was able to record in writing the interactions that seemed emotionally intense, as well as repetitive.

The transcription of interviews was a lengthy but rewarding process that I did on my own. I transcribed all of the ten providers' interviews and twelve of the twenty patients' recorded interviews. After the twelfth patient interview, I realized that patients' accounts were starting to show some repetition so I stopped the transcription process. As Lindlof and Taylor (2002) remark, "When researchers have their work professionally transcribed, they are at least partly alienated from the transcription" (p. 205). By choosing to transcribe the data myself, I developed familiarity and closeness to the interviewees and to their accounts and consequently created a deep understanding of their experiences. While transcribing the interviews in the U.S., I felt re-transported back to the place and time when they occurred. For example, I could visualize the participant's pain stricken faces as they recalled the loss of a loved one during a difficult hospital visit, while I heard cars honking in the background as people carried on with their busy and challenging lives. I transcribed 134 pages worth of raw data. Approximately 100 pages were transcribed in French from French speaking interviewees. My fluency in both French and English languages as well as my closeness to the Cameroonian culture enabled me to transcribe the data and translate it from French to English while retaining the colloquial meaning used by Cameroonian French speakers. Attempts to use professional translating devices from French to English proved inefficient because they failed to capture the nuances of the French Cameroonian

dialect present in the interviews as well as the colloquial meaning of several French Cameroonian expressions.

Research on interviewing and transcribing suggests that no universal form of transcription is deemed appropriate for all studies; instead the criteria for choice are the theoretical implications and practical restrictions (Lindlof & Taylor, 2002; Mishler, 1986). Because of the limited amount of research done within this complex cultural context and the nature of the issue researched, I decided it was imperative that I provide detailed accounts of the participants' interviews. Thus, I used close translation of raw data, only using minor editing. I included onomatopoeias (nonverbal utterances), pauses, nonlexical expressions, repetitions and emotional reactions to fully capture the participant's accounts and meaning. As Mishler notes, "Systematic transcription procedures are necessary for valid analysis and interpretation of data." He adds, "Some minimum level of detail is required for any study but how fine this detail must be depends on the aims of the particular study and remains a matter of judgment" (p. 50). Thus, acknowledging the complexity of the Cameroonian French dialect and the richness of its meaning, I decided to provide insight to the meaning carried by interviewee's words by including some colloquial French expressions as they were used during the interviews, and I provided explanation for them in brackets to preserve the meaning attributed by their authors. For example the word "contrat de confiance" [agreement contract] carries more weight in its colloquial meaning in Cameroonians' use of French, therefore I reported the French expression as they were expressed, "contrat de confiance," and then I explained the meaning of these expressions in brackets adjacent to the phrase. After completing the transcription and translation, I presented and analyzed the data.

It is important to note that despite my familiarity with the Cameroonian context, my interpretations and translations still contain some elements of my subjectivity. Hence the choice of the qualitative method through which the subjectivity of the researcher and the researched come together to create a new reality and a greater sense of shared meaning (Keyton, 2006). In order to facilitate the reading of the findings, I provided a substantial amount of quotations in order to distinguish the participants' voice from my researcher voice. While sorting through data gathered from interviews and observational research, I used my research questions to guide the transcription process as well as the analysis. The gathered data came from the interview questions that related to the general research questions.

Data Analysis

Lindlof and Taylor (2002) define data analysis as "the process of labeling and breaking down raw data and reconstituting them into patterns, themes, concepts, and propositions" (p.210). For the purpose of this study the method of analysis is qualitative inquiry using in depth interviews. Unlike other forms of interviews, in depth interviews require more time to allow the researcher and the participant to build rapport (Lindlof & Taylor, 2002). They also make room for interviewees to share their narrative accounts, providing deeper meaning pertaining to the participants' experience, and illuminate how they embed values and reasons in their narrative responses. My interview questions were prompted by grand tour questions, leading participants to provide me with relevant narrative accounts about patient-provider encounters. I anticipated narrative responses because Cameroon is an oral culture where people communicate their experiences using stories.

As Mishler (1986) suggests, the use of interview questions that encourage stories in interviews addresses the problem of interviewees failing to connect their responses in a sustained

account, which is a reoccurring problem with the regular question and answer model of interviews. I took into account Mishler's advice in the way I conducted my interviews by using interview questions that provoked participants' narrative accounts and caused them to answer questions in a coherent and consistent manner, providing me a clear and solid understanding of their conceptualizations and perceptions concerning the connections between health, religion, communication and dialogue. To make sure that my participants would be able to use stories to respond to my interview questions, I used questions that would elicit personal narratives and natural, vernacular speech (Mishler, 1986). When transcribing my interview data, I realized that providers and patients did indeed provide responses in narrative form.

In order to answer my research questions for this dissertation, I decided to code the narratives according to thematic categories that related directly to my research questions. In conducting a thematic analysis of the participants' stories, I moved away from the question of "whether there exist typical and perhaps universal story structures" (Mishler, 1986, p.73) to examine the critical cultural and health issues that emerged from the narrative accounts. According to Braun and Clarke (2006), "a theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (p. 11). As Braun and Clarke (2006) suggest, "an important question to address in terms of coding is what counts as a pattern/theme, or what size does a theme need to be?" (p. 11). Thus, while conducting my thematic analysis of participant's stories, I looked for patterns related to the themes or meaning of the stories. Braun and Clarke also note the importance of clearly determining what counts as theme or pattern, so I specifically looked for frequency and intensity of reoccurring issues broadly related to my research questions, highlighted those themes and looked at how often they appeared and then examined the

underlying emotions that I noted about the interviewee's verbal and nonverbal expressions of these themes. My coding strategy was in line with Braun and Clarke, who claim that the importance of a theme is not necessarily dependent on quantifiable measures-but in terms of whether it captures something important in relation to the overall research question" (p. 11).

After identifying a preliminary list of several emerging themes from patients' and provider's stories, I organized them according to categories derived from my research questions. I coded themes from participants' responses about physical health, moral health, spiritual health, emotional health and financial health emerged as themes from my participants' stories. Thus, I coded them under the category of beliefs about health. Then, following the advice from qualitative research scholars, I searched for general thematic categories. I coded subcategories as subsets of those main categories according their frequency and intensity in the interview data. For instance one of the prominent subcategories of health beliefs was conceptualizations of health.

As mentioned earlier, I used the field notes for comparison with my interview data. Therefore, after identifying themes from the data, I consulted my field notes and looked for consistency between the observed interactions and the interviewee's accounts. For example, themes, such as touch, financial health, compassion, treatment as family, cultural expectations of health providers, were recurrent in the data from the field notes. Thus, the field notes were indeed a form of support for the interviewees' narratives.

Because this is a qualitative research project using in-depth interviewing, as the interviewer I embraced my subjectivity as the instrument doing the data collection and used this as an asset in gauging the validity of the accounts I gathered from my interviewees. According to Seidman (1998), to test the validity of account from in depth interview, it is important for the

interviewer to pay close attention to the internal consistency existing within each individual's accounts and the connections of verbal and nonverbal features of their messages. In reporting and analyzing the stories of the interview participants, I purposefully looked for internal consistency and contradictions, complementing them with nonverbal expressions for support and contrast. After each participant's quote, which I used to elaborate on emerging themes, I added an interpretation that gauged the validity and meaning of the stories.

In order to answer the research questions derived from the review of literature, I conducted systematic and thorough data collection using both participant observations and in depth interviews. Considering the unique characteristics of the researched population, the analytical method that I used in order to develop my study was a careful and systematic thematic analysis of narratives. The present methods chapter restated the goal and research questions; explained the role and identity of the researcher; described the field interview process; described the assumptions of the interviewing process; identified the interview procedures; and explained how I analyzed the data. While it is important to recognize the potential influence of the researcher as a young educated woman interviewing in a "low-literacy Cameroonian context," it is also important to acknowledge the researcher's familiarity with the culture and her practice of dialogical ethics during interviews as a researcher asset rather than a liability.

CHAPTER 4:

ANALYSIS OF HEALTH BELIEFS AND MEDICAL PRACTICES

My study utilized a narrative analysis of the themes from the interview data of 10 providers and 12 patients. My thematic analysis of this data yielded several general categories and several subcategories. The present chapter provides the findings to the research project in relation to the following research questions; RQ1: How do the assumptions of the Western medical model intersect with those of the traditional native culture in patient-provider interactions?

RQ2: How do Cameroonian providers and patients conceptualize health and illness? I divided the data analysis into beliefs about health, health settings, and assumptions about traditional versus scientific medicine.

Beliefs about Health and Illness

Western literature discusses health beliefs as attributions that people make about health, based on their assumptions about the world (Janz, Champion, & Stretcher, 2002). My research found that Cameroonians' attributions about health and illness are culturally divergent from the Western norm. My interview participants' beliefs about what health means and how health care functions illustrate these differences.

Table 1

Themes and Categories

Themes	**Categories**	**Sub-Categories**
Beliefs about health and illness	Conceptualizations	Physiological health
		Moral health
		Emotional health

		Spiritual health
		Financial health
Health Care Settings	Waiting time	
	Rule Following	
Science versus mixed medicine	Mixed medicine	
	Science and logic	

Conceptualizations of Health

Common conceptualizations of health among participants are that it includes physiological, psychosocial and emotional well being. However, Cameroonians' conceptualizations of health add two important dimensions of spiritual and financial health. Conceptualizations of health as spiritual derive from Cameroonians' perceptions of reality as both physical and metaphysical. Such approaches to reality are rooted in traditional African philosophy (Mbiti, 1970). While the notion of financial health also dates from pre-colonial traditional Africa (Mbiti, 1991), it continues to hold much relevance in light of the economical crisis that today affects Cameroonian patients and doctors.

Physiological Health

The most readily available conceptualization of health for both Cameroonian doctors and patients seemed to be physiological health, which is associated with being relatively physically well and free to be productive. Krist, a Christian college student, said:

> I am in good health when I feel good. . .well physically. I do not feel any fatigue, I do not have any head aches, no stomach aches. In fact I can walk around without being concerned about any pain anywhere. I know that people always have problems so when

> these problems do not bother you too much [and] since we always have something that bothers us. But when you know that you can at least go to work you are okay.

In his explanation of what it means to be in good health, Krist focused solely on his body as a marker of well being. Interestingly, for Krist being in good health does not necessarily suggest that the body is functioning perfectly and that it has no anomalies, rather it means that the body is well enough for the person to freely perform daily activities. Krist's explanation is perfectly in line with the reality of the average Cameroonian who cannot afford to go the doctor as soon as the body shows the slightest sign of weakness or dysfunction. Besides patients like Krist, several doctors, including Lescien conceptualized health as physiological and functional.

> I feel in good health when I do not have a problem, something unusual, something that bothers me…[for instance] I can not see well….When I am in good health? Well, first of all everybody always has some kind of problem so when those problems do not bother you too much then you are ok…since you always have something that bothers you….but when you feel as if you can still go to work you are fine.

Lescien's primary conceptualization of health was also physiological in that he related good health with proper functionality of the body. Interestingly, just as Krist did, Lescien suggested that there is no such thing as perfect health. Health starts from the moment when the individual's body allows him or her to work freely. The consistency in the conceptualization of functional physiological health for both patients and doctors is linked to the local economic reality.

Moral Health

In addition to physiological health, the concept of moral health was a prominent theme among interviewees. In French the word "moral" is often related to more than just the mental

state of an individual; it is extended to include individuals' relation to their social environment, and possibly to the sense of duty that one has to members of his or her community. Rey, one of the local doctors at one of the public hospitals, states:

> If I am not hurting physically or morally then I am in good health. For example [I am not in] a difficult situation. [If] My daughter cannot go to school…I cannot be in good health, I am stressed, I am stuck, psychologically destroyed. Everything that can reach me mentally and physically affects my health.

Besides his conceptualization of health as physiological, Rey explains that health is also mental and moral; that is, he would be psychologically unstable if he failed to fulfill his moral duty to his daughter and this state of psychological stress would deprive him of good health. Clearly, the previous conceptualizations of health suggest a broader definition of health than is used in the US. In the Cameroonian context, lack of ability to fulfill one's duty towards those who are under one's responsibility constitutes ill health.

Another doctor working at one of the main local hospitals named Ledis mentions physiological and moral health as critical to well being. In his conceptualization of moral health, Ledis simply focuses on the symptoms of moral ill health:

> Well, I am in good health when I have moral and physical well being that is it for me… that is health. It is not only physical but it is also being morally balanced; and then I would say that the person is in good health. This includes that one does not have any anxieties, any factors of depression. The person feels safe and the person physically has no handicap, no fever, and no head ache.

Ledis explains that to be in good health is to be physically and morally well. Ledis' definition of morally well focuses on being stress and depression free, but it does not allude to the cause of

stress. Such conceptualizations of moral health suggest that moral health is interchangeable with the ability to fulfill one's duty towards others and the experience of freedom from mental stress of any sort.

Being aware of patients' conceptualization of health as moral can lead the doctor to broaden the patient-provider interview process to include questions pertaining to the patients' perceived failure or success in the fulfillment of their duties towards loved ones. Answers to such questions can help the doctor not only in the diagnosis of the patients' ailment but also in suggesting an intervention plan. If the intervention plan aggravates the patients' inability to fulfill their duty towards loved ones, the patients likely will fail to implement the intervention plan.

Emotional Health

Relevant to recent developments in health literature were accounts that conceptualized emotional health. Coeur, a local Cameroonian doctor at a local public hospital, said:

> So I feel in good health when I have physical, mental and moral well being. Moral well being, well it depends, if you consider moral well being, in moral well being you will have multiple dimensions including affection. You can lack affection…in which case you do not have well being. You can miss people around you. One can actually commit suicide just because he does not have anyone to live with.

Coeur's conceptualization of health and Coeur's subsequent excerpts suggest that health is more than physical and moral well being, but it is also emotional well being. He conceptualizes the individual as multi-dimensional, that is, physical, mental and emotional, and he highlights the fact that lack of emotional attention to an individual can make the person ill to the point of death. Death might occur in the form of suicide where the patient experiences a great lack of affection

and commits suicide to end his or her misery. Subsequent accounts of Coeur in dealing with some of his patients confirm the importance that he attributes to emotional health, as well as the patient's lack of overall well being when emotional health is needed.

Spiritual Health

Departing from Western conceptualization of health care and as an extension to the existing knowledge of traditional African spirituality and health as spiritual peace, Kloklo, a Cameroonian young woman who identified as Christian, said:

> I have had something like that happen to me, I have had a spirit of fear. I was not sick that is physically. Right now I would be ok…but maybe tomorrow I would be afraid. I would not have any appetite…I would loose weight ….they [Westernized doctors] look for what is wrong and they cannot find anything….It is all fear. [fear would manifest through] dreams….When I have bad dreams…maybe when someone suffers a lot around me…. I start to be afraid for the person for myself. Sometimes I am just afraid for no specific reason….I could even have fear because of a piece of plastic.

In the preceding account Kloklo explains her experience of lack of well being and calls it "having the spirit of fear." In other cultural contexts, Kloklo's experience can be interpreted as strictly psychological, but the nature of reality in the Cameroonian context includes metaphysical experiences that stretch beyond psychology to include the domain of spirits. In this case, Kloklo described a rather familiar experience in the culture, the *presence* of the *spirit* of fear in her life. Lack of health because of perceived spiritual harassment is part of the African traditional belief system and also part of the beliefs of some Christian denominations in Cameroon that consider a person part body and part spirit. Thus, for the individual to be in good

health, the spirit of the person must also be free of any form of oppression. In order to be freed from the *spirit of fear*, Kloklo seeks help and intercession from a greater spiritual power.

> My fear makes me lose weight and all, but as soon as I pray….I mean these fear spells can last for two consecutive days but once I pray seriously, the next day I have peace. It came upon me last week, I went to see a pastor and all and one of them gave me some Bible passages to read. I read the passages though they did not really help. Once, I put the passages aside, and I focused solely on prayer.…I said only one prayer. I told God may his will be done in me that is it. I was praying normally and the fear left me. It left and I felt better. When it happens to me no one understands me. Some people actually get frustrated with me as soon as I explain that it is starting all over again. They insinuate that I am making this up or it is my fault.

In the midst of her struggle for well being, Kloklo first tries to recruit the help of doctors to intercede for her body (physiological health), but she was told that the problem was not physiological. Lacking the emotional and social support in her family, Kloklo turned to religious leaders for intercession as is traditionally done in cases of ailments that seem spiritual in nature. Before the coming of Christianity in Cameroon, community members could solely rely on witch doctors for spiritual intercession, but now Christian religious leaders constitute a second option. Unfortunately after visiting with her religious leader and engaging in the suggested religious rituals, she still found no relief. When Kloklo decided to personally appeal for the intercession of God, a spirit that she knows to be greater than the spirit of fear that torments her, and she found peace. While Kloklo did not label her sense of peace as a form of spiritual health, her account suggested that before prayer, despite the sense of relative physiological health, Kloklo lacked spiritual well being.

By defining health as a state of well being, Cameroonians engage in practices to treat the self, that is, to make the self feel better. Not only do Cameroonians define health differently than most people in the West, but both doctors and patients act upon their definitions in ways that reflect this complex understanding of health.

When asked to define health, Revers, a young Christian man from Cameroon, referred to his physical and emotional health. When I asked what he did in order to be in a state of well being, Revers added to his definition:

> I am in good health when I feel well in my flesh…physically, if I am not hurting somewhere inside. If nothing is bothering me, emotionally. This [state of well being] is something I am experiencing more and more these days, it is when I participate into a time of worship with friends from Bible study or from other churches.…Yes, physical well being and spiritual well being are very connected.

In the process of explaining what it means for him to be in good health, Revers acknowledges that religio-spiritual activity contributes greatly to what he calls his spiritual well being. Revers' account suggests that in the context of contemporary Cameroon, people are aware of their need for spiritual well being, but they have trouble connecting spiritual well being to the notion of health that was formally introduced as a physiological concept.

Financial Health

Financial health is another dimension of health that emerged from Cameroonians' accounts. This sense of health mirrors what African traditional literature (Mbiti, 1991) suggests about individuals' goods and financial assets constituting an extension of themselves. For this reason, I was not surprised to hear the complex conceptualization of health provided by Lescien, the local doctor. He said:

> Well being is also your mood....I don't know…whether or not your projects succeed, well if at the house no one is complaining… if you have enough money.

When put in context, Lescien's statement suggests that well being is also financial peace, a sense of contentment with the state of personal and or familial resources related to material prosperity. The individual and the family members have nothing to complain about when it comes to material resources, because there is enough money or material resources to be safe from harm. Ladia extends what Lescien says when he connects financial well being to having enough money to be content.

> Generally health it depends…I think that it depends…there is physical health, moral health, but there is also financial health. Financial health for me, I believe that someone who has financial health is able to take care of his needs that means he can go to the hospital, pay for his consultation, pay for his medicine, pay for his health exams, at the house he can pay for his food for the day. I mean the person is sure to afford a daily meal everyday, sure to afford his medicine, sure to afford his transportation…that is what I am talking about. I am not talking about having a whole lot of money in your bank account but having the basic financial minimum to live right.

In their accounts both Lescien and Ladia conceptualize financial health as a state of contentment with material resources including money. In Ladia's account, however, financial health serves as a source of health power or health insurance: having enough material resources to protect your body from harm such as hunger, illness, possibly sudden crisis. Interestingly, these doctors' responses show that their patients are more than just physiological entities; they acknowledge that patients also have a financial self whose presence cannot be ignored in the health care settings.

Health Care Settings

Cultural conceptualizations of health are closely tied to cultural attributions about the provision of health in a clinic or typical health care setting. Cultural attributions about the provision of health are the ways in which people make sense of services, such as health care, in light of their cultural beliefs about health (Janz, Champion, & Stretcher, 2002). As mentioned in previous chapters, traditional health care in Cameroon used to be less structured and more available than it is now. The westernization of health care brought new infrastructures, redefining the norms and rules for consultation and access. Some of the recurring elements that surfaced in my interview data include: the waiting time for consultation, the need for following of rules, the mixing of Western and traditional medicine, and the centrality of science and logic for understanding how health care is delivered. .

Waiting Time

One of the recurrent issues mentioned by patients was the "waiting time for consultation." Patients found the waiting time endless and attributed this to the lack of humanity that is part of the Cameroonian health care system. Revers, a young married Christian patient, remarked:

> I have had to deal with some doctors…ummm…they pick and choose patients. People come in a certain order, they are in the process of waiting and he [the doctor], for tribal or personal reasons, chooses to consult people who are not in line or people who are at the end of the line…people who are giving him personal calls. He would even take the time to get out of his office to welcome them and when other patients attempt to complain to him, he does not care one bit, he shows that he does not care.

Revers' account highlights a two dimensional issue with waiting. First, the average amount of time spent while waiting for consultation is relatively long because of the low doctor to patient ratio. Second, the extent of the waiting time is unclear because at any time "a special patient" might be placed right before a regular patient. Therefore the waiting time is psychologically extended by an atmosphere where patients feel cheated, ignored and belittled by health care personnel.

Gran, another single Christian, shares his disappointment:

> When I was going in for this illness, because Mom told me since I was not awake, I was in the coma. She first took me to the main hospital. She arrives, she is scared...the state of my child…a doctor approaches her; he says "Madame" we cannot for the moment. For the moment we really can not care for your child because we have patients who are injured so you need to see…while I was dying…so this is how she took me to another hospital [highly emotional pause].

Gran's account reveals the patient's frustration with unrealistic requests to wait. In this case waiting as suggested by the provider may have meant the death of the patient. In his account, Gran seems to suggest that the health provider's request to wait showed a lack of good judgment and compassion considering the seriousness of the illness.

Norman, a single Christian, shares his story:

> My mother is usually very sick and this time, I was the one to take her to the hospital. The negative experience I have with doctors is that when you arrive with a case that you believe is very serious…you are there, the patient complains…the doctor does not care since he tells you to go and pay for the consultation fee…come back…go do this and find a waiting room, meanwhile the doctor is seated there, he can care less….And even when

> the patient is admitted and placed on a hospital bed, you go and see the doctor and he will tell you go and wait for me in the waiting area, ten minutes later, you are still distraught. At the end I understood one thing; if you take your patient to the hospital and it was his last hour….he will definitely die. So you should not take your patient to the hospital when it is very serious. You should take the patient before it becomes very serious. If you arrive at the hospital, and it is already very serious, you have 90% chances to lose your patient because you are not an influential person.

Just as Gran does, Norman expresses his frustration with providers' requests to wait or with a purposeful delay of consultation while the patient is threatened by death. Norman also seems to perceive these requests as an evidence of total lack of care and compassion. In the process of expressing his frustration, Norman provides advice to other patients or a patient's relatives; he suggests taking the patient to the hospital before the last minute.

According to Norman the only ones who can afford to bring their patients to the doctor at the last minute are people who have high status in society or financial influence. Norman adds:

> When you have a certain influence or status in society then you are better treated, but when you are a common person, you will have to exert and use a lot of influence….Go and see this doctor or this other person that you know at the hospital who will come and demand the immediate provision of treatment for your patient….This was the case for my dad. He was in the last days of his life very sick. A man who served at the hospital [a nurse], they asked to send him to the reanimation unit [where they send very serious cases in need of special machines for life support]. And it took two days for the health personnel to transfer him in the reanimation unit. He had diabetes, it had eaten up his body so much that at the end, he would run out of breath right there, I would see him

> lose his breath….I had to maneuver. In the middle of the night, we called a doctor so that he could call his colleagues so that they could finally agree to take my father in the reanimation unit as a suffering member the health care personnel….It did not happen immediately after the call….It is the next morning [after the maneuver] that they finally admitted him and two days later he died.

Recalling, the interview with Norman, I remember the disappointment on his face as he seemed to relive the sense of helplessness that he experienced while seeking care for his father. First, Norman emphasizes the fact that health providers tend to be indifferent to patients even if they are in need of immediate care unless the people seeking care are influential. So for those who have no influential power, it is important to account for health providers' indifference and prepare for unnecessary waiting time by bringing in the patient ahead of time.

In cases of emergency, those with no influential power will need to appeal to people in their social network who might have influence or who are part of the health care setting so that they can ask someone else to intercede on their behalf, requesting the immediate care of the patient. In the process of explaining the last strategy, Norman mentions that his father was a nurse that is a member of the health care system who ironically was deemed "not influential enough" to get the attention of health providers. Norman had to contact another doctor outside of office hours who finally called other health providers and told them to pay attention to the seriousness of the illness and the need for treatment, but it was too late. Patients' frustration seems to be aggravated by the fact that the treatment is often readily available but wait time is manipulated by health providers to their own advantage and preferences.

Rule Following

Besides the waiting time in health care settings, rule following is another aspect of health care mentioned mostly by health care providers. Several health providers claimed rule following is one of the important criteria for patients to understand. Health providers noted that the key rules that patients need to follow are the consultation requirements set by health personnel or doctors' strong recommendations regarding treatment or a healthy lifestyle. Patients seemed to be open to rule following, but they viewed rule enforcers, who are primarily nurses, as rude and inconsiderate.

Leba, a young Christian patient, expressed his dissatisfaction with the rule enforcers among health personnel despite his own attempt to closely respect the rules:

> I was going to the hospital. I am this kind of guy…when I am sick and things are not going well I go to the hospital, if they ask me to do things like buy a health notebook I buy it, if they ask me to buy this or that I buy….So when I arrived, I paid for my consultation fee as required; this gives you the right to receive care and treatment. So how much is the consultation fee? I was told 3,500 francs [about 7 U.S. dollars] ….Okay, so I paid the 3,500. Once I paid, they asked me to go get my temperature, tension [blood pressure] and other personal check information in another room. When I arrived before the health personnel, I was sent to a nurse. She said: "Here you have to purchase a thermometer [for us to be able to use it for consultation]." "I said but the money that I paid for consultation and all… what was it for again?" She answered, "That is just the way it is here, you must purchase." And she started scolding me saying, "When you come here you speak loudly [loudly as with authority over others]." I told her squarely that I would not purchase the thermometer when I have already paid for all the health care by purchasing the consultation fee at the hospital entrance. I am not buying anything….she

started arguing….I told her, "Okay if you do not allow me to proceed, I am going to go straight to the doctor."

At the beginning of the account, Leba expressed his desire to abide by the rules and requirements set within the health care facility. During the interview, he recalled his question to health personnel regarding the price of the consultation by highlighting his desire to pay the price, which is usually the harder rule to follow considering most patients' financial struggles. However, Leba's rule following seems to be challenged by the nurses request for further spending and her reaction to Leba's demand for explanation. From this point, the nurse seems to perceive Leba as a non-submissive and rule resisting patient who lacks respect for her authority as a nurse. Therefore to the nurse, Leba probably embodies a rejection of her authority, and he views her as potentially unable to enforce rules. The nurse also makes references to other cases when people rejected her authority as rule enforcer. This might explain her growing defensiveness, denial of further explanation and change of tone, and her attempts to exercise her authority.

For Leba, the nurse seemed to be the embodiment of health care rules as well as an obstacle to health care access. In his fury, Leba decided to go around the obstacle and go straight to the doctor. Here the patient's aptitude for following the rules is clearly influenced by the way the rules are given and whether or not a rationale for these rules is provided.

Mixed Medical Assumptions

Whether or not patients have to wait for consultation or follow unnecessary rules, the mixing of western assumptions of medicine with Cameroonian cultural assumptions about health creates an overarching paradigmatic struggle in health care practices in Cameroon. While doctors, such as Queen, remained neutral about the option of mixing western medicine with

alternative health care (mainstream or Native religious care) practices in Cameroon, Rey expressed reservations about some forms of alternative treatments. Queen stated:

> [Patients feel like] we need to go to a priest…even when the problem is medical…[they can] handle it in a medical and in a religious way. And that right now if the patient feels that way I give it to him, you know, because it is his right to think what he thinks and sometimes you need to agree to the person's psychology.

While Queen clearly articulated her preference for integrating religious beliefs into her medical practices, she also expressed her openness to patients' dependence on religion as a valid source of health care. Queen also advocated patients' freedom of choice about alternative health care, including religion as part of her personal approach to patient-provider relationships.

Rey was also open to patient-provider discussions concerning alternative care; however, his feedback to patients' accounts seemed more supportive of the belief in God and prayer. He stated:

> I had a patient today, her doctor is in one of the other main cities. The patient comes from that town [to me]. Her doctor tells her that she has never seen this specific disease [let's say the name of the disease is "Rabira C"]…that is the illness of the patient, Rabira C lasts that long...while this is an illness that lasts....I mean if you are told that you have Rabira C, it will not end tomorrow. Rabira C can calm down, it can go away for a month, but you will have it all your life….So the doctor in the other town told her, listen I have never seen a case of Rabira C last so long. Your doctor [referring to me], you can tell him to write you a recommendation for days off to go see a traditional doctor. I asked her: "why didn't she write you a recommendation for days off, she is a doctor too." She answered, "Huh?" "No," she said that she is not specialized in this specific area of the

> body and that you are the doctor who diagnosed me with the illness, so you have to be the one to suggest the days off. So there are doctors who advise patients to go see traditional doctors. But as far as I am concerned if I have an advice to give…always to my patients, I tell you pray to God. I might not send you to your spiritual leader because I do not recall having told anyone go and see your pastor or else but I would say listen pray…the time has come.

Rey's remarks show that some doctors, such as the one in the other town, believe in the power of traditional alternative medicine and acknowledge the syncretism of Western medicine and native medicine as a cultural reality. However, within the Cameroonian health care system some health providers, including Rey himself, do not believe in the power of traditional healers as much as they believe in God and the power of prayer. Therefore, while Rey's approach to medicine and suggestions to patients still allow for the mixing of beliefs outside of science and logic, they are not necessarily inclusive of all alternative ways of healing. During the interview, Rey wanted me to understand why some doctors encourage their patients to use the services of traditional doctors and others do not. He encouraged other spiritual alternatives. In the three previous accounts, the doctors clearly acknowledge the possibility of mixing Westernized medicine with alternative ways of healing, be it Christian religion or Native religion. However, Queen and especially Rey shy away from suggesting traditional medicine unless the desire for practicing traditional medicine comes first from the patient.

Bob, one of the older doctors, also acknowledged this alternative, specifically traditional Cameroonian medicine, as one of the options used by locals when western medicine is not available. He relates his position to his personal experience:

> I was born where there was no hospital in the whole place. When you became sick they would take you to a Native doctor first, so most of the treatment was made in the villages. A native doctor gives you helps and you would get well…but today it is not the same thing….When you get sick today, uhhhh they take you directly to the hospital set up.

It is important to contextualize Bob's account in context. As someone who experienced rural traditional ways of life when Westernized forms of medicine were absent or limited, Bob might have had more exposure to these beliefs and usage of traditional medicine than Rey and Queen. Therefore, while he might not recommend Cameroonian traditional healing practices to his patients, Bob clearly acknowledges and understands his patients' dependence on traditional healing, and as Queen mentioned earlier, he uses the patient's psychological mindset about traditional healing in conjunction with Western models of health care.

Despite health care providers' acknowledgment of the importance of the alternative traditional medicine paradigm and patients' tendency to mix western medicine with other resources for health, most doctors remain dependent on science and logic as primary ways to understand physical health, life and the preservation of life.

Science and Logic as Preferred Approaches to Medicine

Taking a scientific or logical approach to health is to rely on knowledge that has been tested and verified by scientific authorities while managing the care of patients. Science and logic are at the heart of Western and Westernized medicine. Therefore it is not surprising to find out that Cameroonian doctors who are trained in Western contexts tend to adopt science and logic as their primary approach to health care (Li et al., 2007).

Lescien, one of the local doctors, emphasized that logic is the criteria that he uses as a doctor and as an individual.

> Let's say that with the lengthy years of school that we spend to become doctors, you are taught and explained that one plus one equals two….So I no longer make a connection between health and the ancestors…and so forth. For me everything has a rational explanation…so I do not believe that a spell might have been cast on you or it is bad luck….No, every illness has a cause that can be known or is to be discovered at some point. So for me everything has an explanation…a Cartesian approach to illness and everything.

Because of his educational training, Lescien stands out as an exceptional health care provider within the Cameroonian context. Though he seemed to acknowledge his patients' physical, emotional, moral and financial self, he clearly ignores the metaphysical and spiritual world that religio-traditional Cameroonians espouse. For Lescien, the origin of illness and restoration of a patient to health both demand a scientific explanation.

Interestingly, despite patients' tendency to explore traditional sources for healing and health, such as Native religion and/or Christianity in conjunction with western medicine, the scientific and logical approach to health also characterized the viewpoints of the narratives of some of the patients, who talked about the familial environment and their sense making about possessing and lacking health..

Norman, one of the young Christians, explained his family's approach to ill health by emphasizing the value of a scientific understanding of health conditions and practices. Norman said:

> The first thing [that my family would do when I was sick would be] there is a tube of head ache pills at the house...so you take one pill, two pills that you swallow after three hours…then he [the dad] sends you to bed. He will come and ask you "how do you feel? Are you hurting?" You will explain in a little bit of detail. If he realizes that the symptoms match with malaria, he will suggest there…so you will continue taking some of the pills you were already taking.

Leba, another young Christian, also shares his approach to health and lack of health. As Norman's father, Leba uses observation and symptoms of illness in order to take care of his health.

> When I develop an illness, I wait, I do not go, I do not run directly to the doctor. I follow the symptoms first for a good period of time, it can even take a week. Because when I have pains they have to be clearly spotted, I determine their frequency and regularity…because I do not like to go to the doctor and speak vaguely. So when I follow it when I arrive I can tell him [the doctor] that I have this or that happening with this frequency, I have had headaches for two days and it happens with these intervals. After the head ache, this followed or that so I always give clear information to my doctors.

Norman's and Leba's accounts focus on lack of health as a physiological phenomenon, requiring scientific and logical treatment. By watching for specific symptoms of malaria by taking into account published scientific reviews on the subject and by administering Western medicine to control the disease, Norman and his father both show their reliance on science and logic in understanding patients' health care. Leba's observation of symptoms of illness based on scientific knowledge, his counting of frequency as well as intervals of physiological anomalies is a mimicking of Westernized ways of knowing about disease.

It is important to note that even though most Cameroonian health providers working in public hospital acknowledge the importance of alternative religio-traditional care, doctors use science and logic as primary ways of knowing about illness, as well as for defining and maintaining health. It is not surprising that logic and science, which naturally relate to physiological health, are readily used by patients who often utilize mainstream health care. Westernized health care infrastructures also use science and logic in order to regulate services. The use of rule orientation, lab testing referrals, and patients' alignment in waiting rooms are all logical and structural ways to manage the health care system. However, the application of this logical and scientific approach is constantly disrupted by the local nonwestern philosophy so that waiting time becomes endless, rules are disrespected, lab results are not explained, and patients' access to doctors are at times arbitrary.

Thus, the prioritization of physiological and scientific approach to health might be an ideal or a way for individuals to convince themselves of having attained a certain educational status, but the reality of the other ways of knowing and being remains present. While both Norman and Leba live in a socio-cultural context where people are socialized to acknowledge nonscientific aspects of reality, it is likely that purposefully using science and logic as primary ways to understand and maintain health provides these young men with the sophistication and status they desire.

These health beliefs, views about health settings, and assumptions provide the basis for understanding the complexities of the health system in Cameroon. Specifically, my findings in this chapter demonstrate the existence of a multifaceted understanding of health by Cameroonians as a whole. This understanding, which is deeply engrained in people's consciousness, clashes with the existence of Westernized health infrastructures and the presence

of health personnel “trained” to prioritize the use of a Westernized and scientific health model. The cultural struggle occurring within the health care setting seems to resemble a struggle that goes on inside patients and health care providers as they attempt to determine individually and interpersonally what it means to be healthy.

CHAPTER 5:

ANALYSIS OF FEATURES OF COMMUNICATION

The embedded nature of health beliefs suggests both a conscious and unconscious manifestation of these beliefs during interactions. Thus in the present chapter I explore the communication between providers and patients in light of the internal cultural struggle analyzed in chapter 4. I utilize narrative analysis of themes and subthemes from ten patients' and twelve providers' interviews. My thematic analysis of this data yielded several general categories and several subcategories. The data analyzed in this chapter answers the following research questions; RQ3: How does Cameroonian culture, especially Native and Christian religious beliefs, influence the beliefs and practices of providers and patients? RQ4: In what ways do the interactions between providers and patients incorporate narrative and dialogue? RQ5: What are the differences between how providers and patients view the quality or ethical aspects of the health related interactions they have with each other? I divided my data analysis into themes related to my participants' perceptions and experiences about patient-provider communication, dialogue and religious values. The table that follows presents a summary of my thematic analyses of data related to the quality and content of communication.

Table 2

Themes and Categories

Themes	**Categories**	**Sub-Categories**	**Sub-sub Categories**
Patient-provider Communication	Patient and provider responsibility		
	Patient-provider participation	Expectations of providers	Provider's self expectations
			Expectations from patients

			Expectations from culture
		Touch	
		Questions and Answer	
		Trust	Derived trust
			Final trust
Features of Dialogue	Listening		
	Time for the other		
	Treatment as family		
Religious Values	Relationship Values relevant to religion	Humility	
		Compassion	
		Gratefulness	
	Individual Religious Values	Belief in God	
		Christians	
		Fear of death	
		Prayer	
		Spiritual intervention	
		Love	

Patient-Provider Communication

I define patient-provider communication as the communicative exchange that takes place between two parties. However, I also believe that effective patient-provider interactions include ethical practices of care, mutual responsibility for the other, and development trust (DiMatteo, 2004; Kierkegaard, 1995, Levinas, 1996). My interviewees shared some of their narratives about the quality of interaction. Several subcategories emerged under the theme of patient-provider communication: patient and provider responsibility, mutual participation, provider expectations, provider and patient satisfaction/dissatisfaction, mutual trust, verbal questions between provider and patients, and provider's nonverbal touch.

Patient and Provider Responsibility

Levinas (1996) defined responsibility as the response that the self must give to the metaphysical face of the other who is in need of care in order to respect human dignity. According to this definition of responsibility, the responsible self can be anyone; both the patient and doctor are response-able. Despite the philosophical nature of the previous definitions, it is important to note that patients and providers have a cultural understanding of this moral as an interdependent approach to responsibility.

Rey, a local doctor, shared a story about a situation in which the patient and family lacked responsibility, possibly because of their cultural background. Rey explained that he was denied the dignity that he asked for as a young Cameroonian even though he is a knowledgeable physician. He recollected the following:

> One time, I had a patient who really affected me…really. It was in the emergency unit and the patient degraded me. He came to see me and his little three-year-old girl had to have an eye lid surgery. When he realized that I was the doctor that was sent to stitch the wound of his daughter, he was very sad…. Yes, he was very sad…maybe because we were in a Western country at the time. When I started to put in the stitches, he said, "Why, why are you doing it that way? Why are you touching that…why? What are you trying to do, what are you trying to achieve?" Because it was a little girl and it was a facial injury, I wanted to stitch it aesthetically so that there would not be any visible scars. But he did not know, he expected me to put in the stitches as it is done usually. He scolded much and at the end I was hiding what I was doing. While I was working he could no longer see and that was frustrating to him. Once I was done, I moved and let him see. I said here you go, do not put any covering [on the injury], let it heal openly and it will dry on its own very soon. Once he saw and realized all he had said to me, he could

> no longer take it back. He was just in shock, because the stitching was exceptional…that happens…this stayed with me because he insulted me so much…it is really sad.

In his account, Rey expresses his frustration and indignation at the father's communication. Verbally and nonverbally the patient's father denied trust and credibility to the doctor. However as he explained what took place, Rey seemed to experience more than a denial of trust, he was also denied acknowledgement and respect as a doctor. The patient's father failed to appreciate Rey's competence and in return Rey hid the surgical procedure and only communicated once the procedure provided evidence of his expertise. Patients' lack of appreciation for provider's competence can constitute a barrier to patient-provider communication.

Several other physicians shared accounts about incidents in which their faces were threatened and their responses denied. Besides the denial of a caring response to the metaphysical face (Levinas, 1996), one can also threaten the self autonomy of someone else, by communicating in a manner that restrains the other from projecting an acceptable self (Lim & Bowers, 1991). Queen, one of the doctors, shared an incident in which the patient failed to respond appropriately to Queen's competence face while crying out for patience.

> So a lady called for an appointment so I said, "okay, these are the hours you can drop in," and that particular day I was delayed for some reason, I could not be at the appointment that was over here, and I could not come at the time. She said, 'I am at your place', and I said, 'would you just wait for 30 minutes. I am on my way and you see that day…for some reasons I said 'by 30 minutes I'll be there,' and she said 'what 30 minutes…that's a lot,' but that is the maximum, I am just telling you because I cannot make it earlier than that because there are traffic jams and I am on the road at peak hour, at the rush hour. I cannot do better than that. So if you are not free, if you have something to do, why not

> come another day? And she said, "no…no but that is too much…you can't be giving me an appointment and ask me to wait for 30 minutes for you…[raising voice and hyperventilating]." I just repeated myself and said "come back another day and you will have more time. If it is an emergency just wait. You are free to go" and I just hanged up. She called me back, "you hung up on my nose, you don't know who I am, I am a big personality in this country and you are only a small doctor. It is just that you are the only one who has set to be competent in that domain this is the only reason why I am visiting you, it does not mean that I can not go see another one," I said "but you are free to go and see another one…I am not insisting on it. If you need my help just please wait I am on the road" and she…she was just…Yeah. I hang up and she called back again and she said something like that to my nurses too, so yeah…that is very unusual…something that I remember.

In order to better understand Queen's story, it is useful to add to add to Levinas' concept of face that of Lim and Bowers'(1991) concept of self autonomy face in which face is defined as the concern for one's self image (Oetzel, 2009). In such cases the patients exercised their self autonomy face by demanding that the doctor comply with their request to be available immediately without necessarily providing any help or a realistic option for the doctor to respond. The patient denied self autonomy face to the doctor. The doctor also denied an autonomy face to the patient by only giving the patient the option to wait for at least thirty minutes or come back another day. Despite the patient's emphasis on her status, the doctor denied an autonomous choice of responding to the patient. The threats to the patient's and provider's self autonomy face as well as the denial of caring response resulted in conflict and a literal rupture of the patient-provider communication.

Although Queen claimed that instances such as these were unusual, some other doctors mentioned instances where their metaphysical face was denied and the dignity of the patient affected. However, in comparison to patients, the denial of face attentiveness was rather mild for doctors. Patients consistently shared accounts in which not only was face denied them, but the lack of acknowledgement negatively affected the patient's health.

Kloklo's statement illustrates an instance in which the provider failed to respond to her face needs in an appropriate way. She said:

> There was a doctor [gynecologist] who made me cry one day. He told me that I had gone and slept around with men and now I was talking about being an abused victim. And I thought, so I put together the resources to come all the way here to make up stories?! He said, if I do not have money [to get treated], I need to move aside.

During the communication, the provider's statement about Kloklo's condition served two functions. First, it denied the patient the compassion needed in such a vulnerable state of disclosure and emotional trauma; secondly, it blatantly threatened the patient's face deeming her morally questionable, a liar and a promiscuous individual. It could also be that as a man listening to the story, the doctor might have experienced a face threat since Kloklo shared her story that men were the ones accused of assault. In this case the lack of attentiveness to face needs and the threat to face competence resulted in some emotional trauma for the patient and led to unsatisfying patient-provider communication.

Less readily available but also present were accounts of health providers who responded to their patients' face solidifying the patient-provider relationship by tending appropriately to the other's face needs. Coeur, a local doctor, shared a story that powerfully illustrates the sense of

responsibility that a provider has for the patient; this awareness of responsibility enhances the quality of the patient-provider encounter:

> This was a patient who had emotional problems. She loved someone and the person disappointed her and so she developed ulcers. She went to a doctor responsible for the stomach but [she got] no relief. She lost weight and became thin you see. So I welcomed her, I was seeing in her a patient who had grown thin. During that period there was a prevalence of AIDS. I thought but a young girl like this who is so unwell, who seems so unfulfilled, isn't she really sick? [sick with AIDS] Instead of treating her like I should have, I started with …that is when I learned a lesson…I started asking her to go through big exams, testing for AIDS, this…that…then I realized that all [of this] was negative. I asked her a question…do you have a problem somewhere? No, she did not have a problem. But she said that when she comes for consultation, the way we talk, she feels a certain relief. I noticed that I worked with my colleague who substituted for me often. She [the colleague] was a woman, and I noticed that the patient did not like to go to the lady [colleague]. So I was a man, and she felt more relief. I realized that she used to love someone who was a guy like me who had disappointed her. So somehow, I do not know how, she was going through it when she would come in consultation. So, I told her I understand your problem, you are not sick, consider that you are well…as she let go [of the hurt] this is how she healed.

In his appraisal of his patient, Coeur's primary resource was science and logic. He observed the symptoms presented by the patient, compared them to what he studied about AIDS, acknowledged AIDS prevalence at the time; and then he drew a conclusion about the patient's diagnosis. After prescribing tests and finding no conclusive evidence from them for his

diagnosis, Coeur chose to rely on a different resource to heal his patient--intuition. Although intuition is less scientific and more emotional than what Coeur was used to, it helped him to diagnose his patient's ailment. In this case instead of persisting in his initial categorization of the patient, Coeur was willing to humbly abandon his scientific assumptions about the patient, acknowledge the patient and her real need and then to respond in a manner sensitive to the patient.

Patient-provider responsibility is an ethical element of communication that sets the stage for participation. Several doctors mentioned patient participation as crucial to the patient-provider relationship, but also to patients' health outcomes.

Patient-Provider Participation

Participation here is defined as patients and providers interacting through verbal and nonverbal communication that leads to desirable health outcomes. However, it is important to note that effective participation in the patient-provider interpersonal encounter involves the expression and attention to messages in the form of careful listening that allows other people's worlds and experiences to happen to us (McCornack, 2007, Lipari, 2004).

Amio, one of the local doctors, emphasized the importance of patient participation in this response:

> It is true that I generally develop close relationships with my patients, but let say that those who really touched me…maybe because they were very conscientious with their health. They respected everything that I asked them to do towards their health. They respected appointments, despite their multiple commitments, and they did not hesitate to call me, when there were any signs of persisting symptoms from an illness contracted. For this person that I followed for a period of time, for a little longer, I have to say that it

> is a little rare to see that but…this was someone who did her annual exams very regularly, either every six months or every year…this person really impressed me. She works in the banks. It is true that financially she is not rich…but she has […] the means to take care of her health. So she does her exams regularly and she gave me the impression of someone who really follows the recommendations, taking what the doctor says seriously, and not just stop worrying about your health as soon as you are no longer sick.

While Amio recognizes the financial health of his patient and that since she is able to afford various necessary health procedures, he also appreciates her ability to actively listen to her doctor and engage in the recommended activities and treatment. As Amio stated some patients tend to stop listening to their doctors once they gain back their health. Listening seems to be closely equated with patient's compliance with the provider's recommendation. Provider's perception of a lack of participation or noncompliance from the patient has the potential of negatively affecting the provider's participation during future patient-providers encounters. Amio's account suggests that patients who have the financial means to afford recommended tests and exams will be perceived as good listeners, unless the low income patients openly disclose their lack of financial health to the provider. Besides Amio, other doctors such as Queen, discuss appropriate participation and active listening in terms of compliance. Queen shared the following account:

> I say he is my best patient [because he][…]is so particular about his treatment. He goes into the minute details, he takes all his time. He will always ask me and he always calls for an appointment before coming and that is unusual. [People usually just walk in?] Just walk in…they know the hours and just walk in but he always [self interruption]…and

> when I noticed that he was so particular, I let him have the liberty to call me whenever he would like… because it is somebody, [that] is well educated and so he takes the time to read.

Queen's patient initiates participation in the interaction by gathering information about his illness and by carefully following the doctor's instructions. Such behavior shows Queen that the patient is carefully paying attention during the consultations, and in return Queen gives him time and room to be heard (listened to). Thus the key ideas for participation seem to be listening; when as the patient initiates listening to the doctor, the doctor is more likely to genuinely listen to the patient and both can then enter a space where they can communicate in an agreeable manner.

As Queen continues her account, she suggests that her participation in the patient-provider encounter facilitates the participation of the patient's wife, she recalls:

> And the wife too, she is very much interested in her husband's sickness, so the treatment is like…she helping her husband to overcome it so that makes a difference and he always takes his time to make an appointment because he knows that at this time I will be free and he has enough time too. Because when he is over here, even my nurses know that he won't leave the room now so yes so…usually I just tell him you can come around this time…I need to see you so….The way he has …[…]concerns…especially in Cameroon, we encounter a lot of…problems concerning diet. Many people do not like to change their diet, even when they are sick. In some sicknesses, you really need to change your dietary habits. Now he has been very particular about his food and he is very open to dietary changes. This is unusual. He can go into like eating salads three times a day and like that in Cameroon that is very unusual and he comes from the North [Northern part of

> Cameroon].. You are Cameroonian originally; you know how people from the North… they are much more conservative about their dietary habits so you understand why I can call him my best patient and all departments are respected by him.

Queen emphasizes the extent of her patient's participation in the interaction by explaining the patient's sacrifice in respecting the dietary restrictions prescribed to him in order to improve his health condition. Cameroonians from the northern region are conservative in their cultural beliefs and practices and the consumption of specific foods cooked in a traditional fashion is an important aspect of cultural practices. Therefore, for the patient to abandon his cultural customs in terms of food consumption and adopt new eating habits according to the doctor's prescription shows the patient's respect for the doctor's recommendations, and it is also a mark of effective participation.

While participatory actions in the form of patient compliance with the doctor's suggestions enhanced the communicative exchange from the perspective of doctors, other forms of participatory actions, such as keeping extensive records of personal illness and tentative diagnosis, were not welcomed by doctors nor were they considered a feature of quality patient-provider interaction.

Revers, one of the young Christian patients, described the quality of interaction as relating to the extent of the patient's participation in diagnosis:

> Well for me generally, I tell the doctor all that I am feeling, I tell him where it came from, how it started, what I took or what I did to help and sometimes I even have fun and I go ahead and give my idea of the diagnosis there you go. [In response]Sometimes they laugh, but what is strange is that one time it happened to be true, the time when I had [an] appendicitis. Because I used to hear people discuss and say sometimes it does this and it

> does that, so when I had it I thought maybe this is appendicitis. Sometimes I play around like that…[…] But I really say what is on my heart, what I think it is and I think that the doctor needs to know everything I am thinking, all that it took to help and do everything for a better analysis.

From a patient's perspective, Revers believes that effective participation requires self disclosure; that is, the patient needs to give as much information about the self so that the doctor can in turn make a better diagnosis of the health problem. Revers sees intuitional discernment about the potential illness as part of the patient's disclosure, which ultimately helps the health provider in the final diagnosis. According to Revers, in the process of disclosing self and responding to the mutual disclosures, the provider and patient get to know each other through the interaction. Some local doctors showed amusement or frustration with this form of participation.

Lescien, a local doctor, stated his reluctance to hear extensive oral accounts from patients when he talked about his preferences for the amount of communication from patients:

> Generally it is very short phrases. In general it is very short, you are the one who has to ask questions…in general…but as I said there are some who would say "doctor, I am going to tell you the story." So he has a little notebook where he has jotted all of it. He has a notebook where he has written everything that happened to his eyes since I don't know 15 years and he is so determined to read you the whole thing…it is your call to stop the disaster.

Lescien expects limited oral participation from patients during patient-provider interactions, but this does not seem to necessarily impede his interactions. The real problem for Lescien is the overly verbose patient who provides too detailed of an account of the illness. This doctor

believes that it is the doctor's responsibility to stop the patient from talking too much. Lescien's preferences suggest that as a doctor he would rather be in charge in the interaction and guide the participation of the patient.

For my interviewees, the nature of the patient's participation depended on the patient's and provider's preferences, but in all cases the participation of the doctor was assumed to be more important than the patient and the doctor was dominated the conversation in successful interactions.

Expectations of Providers

In terms of participation and overall health outcomes, expectations seemed to weigh more on the provider than the patient including: the provider's self expectations, expectations imposed on them by patients and expectations that rise from the culture.

Provider's self expectations. Providers describe their self-expectations as the burden that the doctor puts on himself or herself to improve the conditions for the patients and to engage in encounters in ways that improve the patients' health. While providers' self-expectations varied in intensity from one doctor to another, Rey's account suggests that the Cameroonian doctors' self-expectations differ from those of Western physicians. For Rey, the status of the patient was more than just another biomedical outcome; it was a personal burden. He said:

> Me personally, if I do something, when my patient has something…with almost all the deaths of my patients, I look for my mistake, can you imagine that? It is real hell [cultural idiom] living that…it is real hell. When I go to my house, I am all alone, all I have is my TV [to turn to]…and I look at it…but I lost a patient…why did he die? This question follows me. This question follows me, should I have done…?[…]Doctors and most of the time people might talk about their job, and they would tell you about how easy their job

is and how they are able to perform it and how simple it is. But it is only talk, when you see actions that is when you can determine who is best and why this person is best, maybe because the person learned well, and was a good student. However, you will find a good student who is faced with an illness and he is stuck. [He is discussing failure resulting in death], Yeah… but listen…when someone passes, I go home and I say, I should have done this and I did not, why didn't I do it? [hushed tone–very emotional].

In this excerpt, Rey's process of self interrogation reveals the struggle that he undergoes in determining what communication he should use when his patients pass away. The struggle is complicated by the difficulty, uncertainty and pain related to matters of life and death. Traditionally and culturally speaking death continues to be the worst of social ills and the source of spiritual insecurity (Mbiti, 1991). Thus, as a doctor Rey expects to save his patients from death and all of its social, spiritual and emotional ramifications.

Expectations from patients. Patients described their expectations for doctors as hopes that doctors can help improve their health situation. While a similar situation can occur in the biomedical health model, in some cases the patients' expectations exceed those found in Westernized healthcare. In this case Coeur, a local doctor, noted that he was expected to act as a social/cultural intercessor for the "social health" of the patient.

Let me give you an example. I had a patient lately, in his family he is the one who has the last word. The father is afraid; the mother is afraid; the brothers and sisters are afraid; and he [the patient] is a twin and he is from the…province. It seems like in this specific province twins are a little… [incomplete sentence – a hushed tone]. So what happened, he created an illness. And he was brought to the hospital. He first lied about having been in an accident and having been traumatized. When he got the hospital, he had no injury on

him, and he could not talk. He was not moving. He urinated on himself, defecated on himself and that was it. However, it was all false…just because he wanted that [colloquial way of speaking] when he does something at the house, everybody accepts it, for fear of seeing him get angry or upset… . That is a problem already…[…] [mentioned his field as a doctor]. I cannot take care of this patient, I would refer him to someone else. At my level I tried to show the patient that he is not in pain or sick. I tried to explain to the family, even though the patient begged me not to tell his parents.

While Coeur's story might sound unique, it is not uncommon for health providers to find themselves caught in the middle of family affairs, having difficult expectations placed on them. In this case, the patient expected Coeur to cover the truth about the absence of physical illness so that the patient could retain some psycho-social "stability" and keep receiving the attention of family members. The doctor was expected to share the cultural reverence for twins observed in certain parts of Cameroon and protect the social interest of the twin patient. However, the doctor perceived the expectation as unrealistic and manipulative. He assessed the problem to be psychological, recognized the need for the patient to be referred to someone specializing in that specific area, and explained this diagnosis to the patient's family members.

In addition to doctors interceding on behalf of patients at a socio/cultural level, multiple patients shared accounts that suggested they expect the doctors to play the role of intercessor, not necessarily for improving the patient's "financial health," but for interceding for the patients' well being considering their state of "financial ill health." Jolly's account as well as Kloklo's personal experience related earlier further illustrate this finding. Jolly said:

There are doctors who neglect patients, especially when they do not have money, because for us here… it is money that speaks [cultural idiom]…I mean money speaks [laughter]

> So when you do not have money really, they would rather that you die. […] Not long ago, I was at the health center. [I saw] how a women who came with her child who was desperately ill. The woman was sent back because she did not have the money required. She did not have the right amount so…[…] The child was to get an examination first but they were asking for money. So because the woman said "no". I do not have money but I will call someone because I left the house my heart was not quiet [idiomatic expression]. […] I did not take money [enough to pay what is required] I am going to call my husband. The doctor said go and wait for your husband on the side. There were also a whole lot of people [long line-so she lost her place in the line]. So me the doctors of today [idiomatic expression] it is money, you do not have money you can die at the hospital. This is true.

Jolly expressed her frustration with the doctor in the story, and she generalized the doctor's behavior to other doctors in Cameroon. During the interview she clearly explained that the previous story is only one account amongst many others where health providers showed a lack of sensitivity to patients' poor financial health. The expectation articulated by Jolly and several other patients was that doctors should be able to recognize the financial limitations of the patients when they dealt with and made concessions for patients who had limited financial health. Instead of causing people with less or no money to wait endlessly in line when their cases are highly critical, the expectation is that providers should give priority to serious cases.

Expectations from culture. Unlike the providers, patients' expectations about the Cameroonian health caregivers included a cultural expectation based on people's hope that the providers would act in a way that is congruent with cultural beliefs, rituals, norms or reality. Bob, one of the doctors, was pressured to care for his patients' health by acknowledging the local

cultural norms, by being accepting as a healer and by being a guardian of cultural beliefs. Bob explained:

> Yes, there are some patients who believe that breastfeeding….their culture tells that breastfeeding can make the child die right…So in most of the areas when they deliver the child, they go straight to adult food to give the child and then some of them, like the one who really impressed me…I tried to convince her not to believe that. Immediately as she delivered, she put her child directly on the breast and the rest of the family was not happy about that because they imagined that when you breastfeed, the child dies.

Using communicative expertise, explanation and trust building, Bob convinced the patient to breastfeed her child upon birth. However, Bob's success was probably unusual for doctors dealing with patients holding strong cultural beliefs that oppose provider's advice. In fact Bob explained that the process of convincing the patient was strenuous and challenging. Other doctors also made allusions to patients' strongly held cultural beliefs, and they noted their great frustration when patients refused to comply with suggested health behaviors. Patients seemed to expect the doctors to understand the cultural beliefs and protect these beliefs when giving advice and recommending treatments.

Despite the overwhelming sense of unmet expectations expressed by patients because of the absence of financial intercession and lack of cultural understanding, the doctors seemed to place high expectations on themselves. Because of the Westernized nature of the Cameroonian health care setting and their medical training, doctors often found patients' cultural expectations incompatible with scientific knowledge. The financial crisis plaguing health public services in Cameroon also seemed to constrain the provider's ability to show compassion to patients. Overall, health providers' management of expectations in light of the constraints in Cameroon

culture could benefit from better communication so that providers could clearly articulate the constraints of the context in which they operate and express the limitations that they have in meeting some of patients' expectations.

Touch

Expectations placed on doctors seemed to affect other elements of patient-provider communication, such as the role of touching in examinations. Rey, a local doctor, addressed the idea of touch and its role in the patient-provider encounter. Rey emphasized:

> The physical exam is an important moment, not only physically but also morally, because I have a lot of stories of doctors who do not examine their patients and their patients do not like them just because of that. "Ohhh, you go to him and he does not even touch you, he only talks to you like that…" So in conclusion, you have to touch your patients, they like it, because it makes them feel important. They feel like you are taking care of them. Physically examining your patients is good. I work here with my boss, a seasoned …[doctor in my field] like him, who has been working for forty years or so, who still examines his patients the same way like a fourth year medical student who is just starting to work. So I have been lucky to have a gentleman like that who reminds me all the time, do not forget, no matter how great you are, to touch the patient's body. So I touch my patients.

Touch behavior differs from one culture to another and in the context of Cameroon, touch is an intrinsic part of human interaction. People touch mainly because the concept of space is nonexistent, but also out of honor and respect, out of playfulness, and to show care and connectedness. Therefore more than the use of touch, the absence of touch carries negative meaning. In the case of the doctor who is suppose to show care and seek connection, the absence

of touch, which is a basic means of communication and connection in the culture, is quite offensive. As Rey explains, the lack of touch can be interpreted as a purposive means of creating distance between the provider and the patient. The importance of touch arose in both health providers' and patients' interviewees.

Question and Answer

Apart from touch, the use of questions/and answers was another key communicative aspect recurring in both the doctors' and patients' accounts. Doctors used questions for the purpose of bonding with patients and as a communication practice for making sure that the patients understood their diagnosis. However, doctors utilized questions to access information about the patient's illness. Bob, a doctor, explained:

> So I allow them to exhaust themselves, and then I ask them directional questions. Questions as way to guide them, for example, if you have a headache, you have chest pain, you have low abdominal pain…all these three symptoms, did they start the same day Madame? She will say "no." Okay, which one started first? These are the types of questions, I guide them. But the rest, most of the talking they will talk because they are the ones who have problems…so I ask specific questions to be able to decipher between a pathology and the other problems.

Bob's explanation of the questioning process is similar to what occurs in regular interactions in which one uses questions in order to get specific information. But it is important to note that in the context of traditional medicine, the healer is often expected to have the divine power to know the details of the patient's illness so fewer questions are asked by traditional healers.

In the context of Westernized health care and while explaining the process of seeking answers for diagnosis or follow up, doctors used words such as “stratagems” or “systems” to describe how they gather information from the patients.

Dr. Rey’s account illustrated this point.

> When you are in front of him you have to use some “stratagems” [schemes] to obtain the information and to be able to manage the situation. Sometimes it is a problem that is not health related that blocks everything…that is why I say that we have systems. Because it is a patient that we have followed for a long time so during each visit you ask him little questions. It is not direct questions no…it is in an indirect manner…so how do you deal with it? Have you told someone what you were dealing with? He will say no…[you ask]why?...I mean you lead the patient to talk about the illness, what he understood, what he retained? Is he in the right direction or is he in the wrong direction?

While Rey’s interviewing strategy might appear quite common in Westernized medicine, the framing of the motivation behind the question is somewhat clandestine. During the interview and while elaborating on his questioning of patients, Rey admitted that sometimes providers have to use tricks to get the information out of the patients. This seems to suggest that instead of working together, patients and providers hold adversarial positions during the consultation. Ultimately, providers use questions in order to analyze the patient’s case and reach a conclusive diagnosis; however, the way in which the process of question and answer is approached can hinder or enhance the patient-provider interaction and relationship.

As expected several patients, such as Jolly, also used questions in order to gain more information about their health status but to no avail:

> I am telling you, I went to the hospital, I thought they would tell me you have this or you have that, but when I got there it was rather a prescription that they pulled out and gave me saying, "No go take this…it will be alright." I asked him in this case what I am suffering from? He answered, "No, it is not that serious." So doctors, they do not take the time to explain, saying this is what we found, this is what you are suffering from.

Jolly was asked to go through expensive tests by her doctor to find out more about her illness, but after getting her tests from the lab, Jolly went to meet with her doctor, asked the doctor about the meaning of the results, and she received no clear explanations. After spending so much money and suffering much pain, Jolly felt she had the right to know what disease was detected, but her questions were left unanswered. Several patients complained of the fact that doctors failed to answer questions asked by patients and when they answered questions, they remained vague. When I asked doctors the extent to which they provided explanations to patients, some admitted that they gauged the educational level of the patient and then proceeded with further explanations but only if they thought that the patient was able to understand the full diagnosis.

The last, but most important element of the patient-provider communication encounter, was trust.

Establishing Trust

The concept of trust emerged as the co-created connection between the patient and the provider that leads the patient to open up, comply to the provider's suggestions, and be willing to return. The construct of trust that emerged from the data relates to explanations of trust in the interpersonal communication literature in which trust is defined as the belief that the one being trusted has in keeping the truster's best interests at heart. In a trusting relationship both parties

have no intention of doing some harm to each other (Brown, 2009). Providers' and patients' accounts suggested that trust was sometimes derived during the first communicative exchanges and maintained during follow-up encounters after treatment.

Derived trust. Derived trust refers to the sense of confidence that an individual builds about someone else through personal interaction. This bond of trust was manifested in a response when the patient opened up on the first encounter with their provider because of the way the provider showed genuine care, concern and a sense of sacrifice. Leba, a patient, explained how his providers' genuine care and sense of sacrifice lead him to trust:

> With this woman [doctor], it was the way she cared for me, and plus her personal phone number she gave me. She told me that she could follow me up personally, when usually you go to a doctor, as soon as you are finished, he says ok bye. Maybe [he will give you] an appointment that he himself will not follow, an appointment that when you come and say we have an appointment, he would have forgotten that he is the one who wrote down the appointment day to follow up with you. But with her, she really wanted to look after me.

Krist, another patient, reinforced the idea of how doctors gain trust from patients:

> It was very late at night and when we arrived, he [the doctor] welcomed us very well, he helped us get settled very well, me and everyone who was with me. And the first thing, I remember we did was…he directly took my weight and he asked me a few questions, how I felt and everything. Afterwards, he asked me if I had my health records and if I had been sick before. Actually, I had my health records with me and he looked at it. He looked at what I had had before and he asked some questions…because I had been sick [with this] for a long time. So he asked me when the illness had started and what I had

> taken for it…and the symptoms…what I was taking. In fact, he was jotting everything, what I had taken, all the symptoms I was showing…he was jotting everything. So then he led me back to settle in. So he really touched me because he was very welcoming and he wanted….He seemed to be like someone who wanted to understand from beginning to end to see really what was bothering me.

In both Leba's and Krist's accounts, the Cameroonian providers showed extraordinary care. In the first illustration, the doctor gave the patient a personal phone number and offered to personally follow the patient. In the second account, it was late at night but the provider took the time to help the patient and family members settle and made them feel welcome. In both situations the health providers offered their time in order to ease the discomfort of their patients. Consequently, for patients to develop trust for the provider, there needs to be the perception that the provider makes a clear sacrifice to help the patient feel better. In this case time was the element of sacrifice. Genuine care for the patient's well being is another element that arises in the two stories. Excerpts from the two doctors showed persistence in their attempts to give extra attention to their patients.

Derived trust also emerged in accounts of doctors who sought to help patients or patients' family members to avoid face threatening situations such as surgery or even death. Arean, a doctor, explained how he used communication skills in order to announce difficult news to the patient. He noted how he gained the trust of the patient in the process of conveying bad news:

> We had a person who came with their only child that we operated on. The family member was right here…but we had to announce [the death of the child]…so should you come out and tell the family member "Well here is what happened?" I am telling you the story, the body was right on the operating table. We started telling the family member that the

> situation was getti4ng worse but we will do everything in our power to save the child. Already there is a shock wave, you send a shock wave that is manageable [for the patient], you understand? And this lasted three hours, I mean from the moment when I started talking the child was already dead, you understand? It lasted three hours, and no one could leave the operating unit, because if you see the main doctor outside, if the family member sees the main doctor outside then there is something wrong. So it is communication, so you have to "amener" [bring slowly] and then at the end when you end up announcing [the patient is open to it and says] "what should we do practically now?" When the patient's family member says that, it's a win, it is over we won.

In his story, Arean presents a very unique situation in which he used communication to create a sense of mutual understanding with his patient's mother who was in the process of accepting the fact that she had lost her child. Arean could not possibly get to the point of the mother's acceptance without building a sense of trust from her. The process of trust building took time, hours upon hours of talking, in which the doctor addressed the woman's potential fears. Ultimately trust was developed during the interaction, and the woman was able to fully rely on Arean for a final decision about making burial arrangements. It is important to note that the present illustration of trust building is ideal. Sometimes the process of gaining other's trust requires more supportive communication. As demonstrated in this example, derived trust is one of the key factors to account for is time in interaction.

> While discussing the need for trust in his relationship with his patients. Lescien stated, In fact, the patient and his doctor, I think it is first a "contrat de confiance"[trust agreement].

The expression “contrat de confiance” used by Lescien carries a weighty tone full of expectations for interdependence in interactions. The expression can be linked back to Arean’s story in which Arean wins the “contrat de confiance” after a long, persistent communicative exchange with the patient’s mother. Thus trust is awarded just like a contract and one must be deemed worthy of it.

Final trust. Final trust is the high sense of confidence that an individual develops towards someone else as a result of past experiences with the person. Final trust occurred when the patients could believe that the doctor had their best interests at heart and would not harm them. For example, Ledis referred to trust during secondary encounters, once the patients had the opportunity to test the credibility (character and competence) of the provider:

> Sometimes I tell my patients, this is the first time for me to treat this type of injury, but I will see what I can do. But I can guaranty you that you will have the best results which would not be bad so he might think…this is someone who has a lot of experience…he has never seen this type of injury, is this worth it [surgery]. I have the feeling that there is hesitation. Their trust is established after the surgery and when they see their results.

Establishing trust helped patients feel as if they could truly open up to their health providers and co-create a new health story with them. In the case of the patient Krist, his trust in the provider led him to respond to an extensive amount of questions, in the case of the doctor Arean his trust building led the mother of the patient to accept the fatal news about her son. Whether derived or established in the ongoing interaction or from past experiences, both patients and providers agree that trust is critical to effective patient-provider communication.

Within the context of patient-provider communication, features of dialogue emerged from the data. As patients and providers indicated, trust is not only a critical element of effective patient-provider communication, but it is also an important foundation for communicative processes such as dialogue.

Features of Dialogue

The construct of dialogue is discussed extensively by Arnett (1986; 2001), who defines it as an intersubjective encounter where the response of each subject is necessary for the purpose of practicing civility and community building. Theoretically, some features of dialogue include responsibility and embeddedness (Arnett 2001; Levinas, 1996). Dialogue is both a verbal and metaphysical interchange between individuals. The ethics of dialogue centers on the responsibility for the other and the embeddedness of the subjects' discourses in historical and cultural contexts. The responses of the participants in this study showed several themes pertinent to features of dialogue. The themes include: listening, time for the other, and treatment of the patient as family.

Listening

Listening emerged as a substantive communication pattern and a pervasive subcategory throughout the interview data. However, some aspects of listening related to the financial beliefs about health and the ways that listening takes place in patient-provider interaction to facilitate healing.

Listening to Voices Embedded in Financial Health

This form of listening refers to doctors' abilities to perceive and acknowledge the patients' financial anguish and to understand how their limited resources impact their health care (health decision making, compliance and worldview). By listening to discern the patient's voice

as located in a specific health situation (Arnett 2001), the provider can respond by recommending an affordable treatment for the patient. Lescien, a doctor, discusses the importance of listening for and acknowledging the patients' financial limitations:

> When it is an emergency meaning that right away he needs to do what it takes to buy all the medicine, to start the treatment…even then you look at the person, you gauge their "financial ability" and you gauge…because if he really needs the medicine and the medicine costs a lot of money, you have to ask the patient the questions. Don't just write the prescription because you saw….They said at the last conference that [because] this was the best medicine, so you heard it and you just prescribe…no you cannot do that [because] after two days the patient will stop his treatment, because he will not have the means to do it, so you need to ask: "are you able to buy? Because those medical products are expensive…When can you start your treatment? Because all of this is important…This is when it is an emergency. "So when can you start your treatment, what can we do?" And you try to see with him if he can pay because if he cannot pay, it is better to start with something that is inexpensive. But at least you do not leave him without treatment.

Lescien's discussion highlights the importance of listening to the patient's voice as embedded in a specific state of financial health. By asking the patient whether or not he or she is capable of affording the medicine or how soon he or she can purchase what is needed, Lescien can assess the patient's financial health knowing that it will ultimately affect the patient's physical health. Cameroon's post-colonial years have evolved into an acute financial crisis. The economic crisis continues to have a drastic effect on most individuals' financial health. Because Lescien listened

for patients' voices as embedded in this specific historical and socio-economic context, he is able to act in ways that are consistent with his conceptualization of health as partially financial.

Queen, who is also a local doctor, also explained how she used listening as means to acknowledge the patient's financial situation. She used intensive listening, what the communication literature calls empathic listening, to anticipate the money needed for the diagnosis and to limit the number of expensive exams for the sake of the patient's financial situation. She said:

> Listening to what the person is saying. I think in poor countries, it is very important to be able to listen to what the person is saying and get information because it will give you fifty percent of the diagnosis. Yes…yes…so you do not need to give unnecessary tests costly tests because it will just delay the person's treatment…so sometimes you really need to…this is the reason why I learned this habit of listening first to what is being said.

Queen's excerpt illustrates the power of empathetic listening and listening in context. As Queen further explained, patients often lack the money to pay for lab tests and other forms of health exams, in which cases the health providers need to use intent and mindful listening in order to provide a "stand alone" diagnosis. Thus the type of listening practiced by Queen is directly related to the provision of an accurate diagnosis, but it also takes into account the patients' financial health and acknowledges their financial constraints.

In addition to this doctor's comments about listening, accounts from several patients referred to the importance of financial listening. Kloklo, a patient, recalled how one of her doctors took the time to acknowledge her financial situation.

> With the last one, when I arrived he did not make me wait, he welcomed me, he was polite, because the others really! Since this particular hospital has a lot of patients, the

> providers receive patients like when you play cards that is how they receive patients, if you want to explain a whole lot of things they kick you out of the office, and they ask you to wait outside. Also if you do not have money they ask you to go wait on the side. This doctor first chatted with me, he asked me some questions and I answered them, then he asked me "explain to me what really happened?" He asked me if I had money, I told him that "well, to take medicine now I do not have the money." I explained to him my mother's situation, the fact that she had lost her job and everything…so that it would be a little difficult for me to find the money. He told me that since those [medicines] are too expensive, he will prescribe others that way we will see, so he was also "putting me in [a state of] trust" [mettre en confiance].

As a patient, Kloklo elaborated on the importance of a provider's ability to listen in context for a patient's financial health. Living in strenuous economic conditions, Kloklo shared her relief and gratitude for this doctor who took the time to ask her whether or not she was able to afford the prescription and made the necessary adjustments to provide her with treatment that she could afford. According to Kloklo such acknowledgement from providers was rather unusual.

The direct relevance of listening to healing was a theme that emerged in my interview data. While this sub-category seemed metaphysical and abstract, it relates to the existing literature on dialogue and medicine. Patients gain a type of health when they have an opportunity to talk and when doctors listen to them. Lescien, a local doctor, shared an account that illustrated patients' strong appreciation of the providers' ability to listen and to emphasize the providers' function as healing agents. Lescien noted:

> You [doctor] are there to listen to them [patients] because he [patient] who comes in, well for him his illness is the most culminating point, the central point of the whole universe.

> He would probably like for the person in front of him to understand the importance of his illness for him…no matter what, whether it is a simple illness or a serious one. If he is in your office, if he has spent an hour or two in your waiting room, it means that he would really like you to listen to what he has and resolve his issue. So if you listen with only one ear, you do not "look," you just write the prescription, he will never come back to you, because he will say "that guy did not even comprehend my suffering."

Lescien recognizes that the gift of listening is a therapeutic element for the patient.. So a doctor who is seemingly distracted or who does not listen to the patient might deny a part of the therapeutic process necessary for the patient to regain health. In order to listen to the patient and allow him or her to happen in a real dialogue, one must allow time to connect with the other.

Time for the Other

As the literature suggests (Arnett, 1986). real dialogue is a metaphysical space for the intersubjective creation of meaning. Both parties involved in dialogue must attempt to make room for the other while controlling the self. The interview data showed that patients perceive sufficient time to be a necessary factor for dialogical interaction and that private space also must be found for authentic dialogue to take place. Antonia, one of the patients, referred to dialogue as the ideal exchange in which patients are free to open up to the health provider.

> No, when I think like that it is so that if the patient feels umm frustrated that he would be free to speak, to tell the provider what is truly wrong. Because when there is no dialogue between the doctor and the patient, the patient can keep a lot of things in him/her…yet when there is dialogue and the patient tries to talk, then you [doctor] would know what to do.

While Antonia does not define the notion of dialogue, her understanding of this type of communicative exchange is that it occurs in an atmosphere where the patient giving his or her account has enough time to freely disclose relevant information and connect emotionally with the provider. The patient needs to experience a sense of "metaphysical room" created by the provider, and this room seems to be partially manifested in time and feeling.

> Fildev, another patient, highlights this characteristic of a positive exchange saying:
>
> It has to do with the length of the exchange. In reality, the doctor should take his time with the patient. That means that he listens to you, he allows you to speak, he listens, you say all that you have to say…

Fildev's explanation of a positive encounter reiterates the fact that time allocation is necessary for the health provider to make the metaphysical room necessary for the patient to communicate.

Time is probably not the only element necessary for dialogue, but it seems to be a critical feature of dialogue especially for Cameroonian patients. The notion of time as critical to dialogue is also consistent with local cultural beliefs related to relational connections. In order to connect with another and disclose the self, one must take the necessary time to build a relationship with the person. Thus another feature of meaningful dialogue is for the people involved in the communicative exchange to feel that they are treated as if they are family.

Treatment as Family

The feeling of being treated as family is closely related to the cultural notion of hospitality. However, instead of receiving someone in your home you receive them and respond to their humanity during conversations. While reporting successful patient-provider encounters, patients often mentioned that the provider communicated with them as if they were family members. In some cases, the successful encounters were actually with providers who were

patients' relatives. The dialogic features were similar for related and non related patient-provider successful encounters.

Jolly, a young woman, shared an early encounter with a health provider who treated her as if she was her own daughter:

> When I think about a doctor […] who took care of me […] I think about a woman here at …[name of the hospital] when I went to give my samples. They had prescribed me injections…I mean she took care of me as if I was her own daughter…she always gave me counsel…she always gave me counsel, and it did something to me….She really touched me…because people, doctors don't just see you and give you counsel no…as soon as he [a regular doctor] is done giving you your prescription, he tells you go and buy this, it is going to be ok. [the health provider who treated her as family] So she said since you are still a little girl when you will grow up in life, do not seek to sleep with men anyhow or do not try to have sexual relationships without protection[…] so those were some of the counsel she used to give me.

While Jolly's account might sound unacceptable in the Western world, it holds narrative fidelity within the Cameroonian context. The provision of counsel is generally perceived as caring and hospitable communication rather than belittling. When received positively, such provisions of counsel usually mean that the person providing counsel is showing a positive metaphysical disposition towards the one in need. Other illustrations of dialogue and treatment as family included listening to patients in need of financial or emotional assistance and responding to the need of the patient as if they were a family member (not expecting any return).

The importance of treatment as family (African families are close) was reiterated by Sam, one of the doctors:

> What we look at is holistic management, the total management of the patient. I communicate with them [patients] as my brothers and sisters. There may be a time when someone might come and say o…I do not have transport money, and I say ooo you could have had…ooo my husband has gone […] I say I lend you that…my money…I say ok…whether you bring or you don't bring. Sometimes the person may come and does not have consultation [money] because...either the husband…for whatever reason…is faithful towards the clinic[…] At every stage, I would tell the people at the reception, please put that consultation up so that when he comes for the review he can pay. In short, I tell myself and I tell my colleagues [to] treat every women as your mother, your sister, your daughter, and every man as your father, brother or son.

By recommending that the staff should treat patients as family, Sam refers to the special care and responsibility those family members show toward one another in the African context. The notion of treatment as family is connected to Levinas' (1996) "call to responsibility" in which the subject responds to the other in need.

Cameroonian patients seemed to conceive the notion of metaphysical dialogue as more than just a verbal intercourse in which voices interact and conversation happens simultaneously. Metaphysical dialogue occurs when my interviewees showed care for the person in need in practical ways that could be verbal or nonverbal. Dialogue contains a multiplicity of voices that cannot quite converge until the subjects' are "listened to" and addressed as human beings who need to be healed. The metaphysical worldview of Cameroonian patients and doctors involve respect and deserve dialogue. This is particularly evident in the connections between dialogue and Cameroonians religious values.

Religious Values

As noted earlier at the core of traditional African understanding of life are strong religious beliefs (Mbiti, 1991). The resilience of religion in Sub-Saharan African ways of life is evident in their adoption of the religious beliefs of Christianity and their reliance on religious faith to make sense of the themselves and the world including their health. Religion continues to be relevant and almost necessary for survival in this part of the world (Ela, 1980). While traditional religious beliefs and Christianity remain the dominant religious views in Cameroon, the interview data makes clear that participants perceive the two religious views as syncretic rather than as separate and distinct. Within the category of religious values, the following themes emerged: relationship values relevant to religion, individual religious values and religion as part of facing death.

Relationship Values

African philosophers often describe traditional Africans as both communal (Moemeka, 1996; Mbiti, 1991) and religious since the people use religion to make sense of reality, relate to their communities (Ela, 1980, Mbiti, 1991). and apply religious values to their relationships. Interviews with participants supported these connections and showed that humility, compassion and gratefulness recurred as relationship values.

Humility

Within the context of Cameroon, the concept of humility refers to the people's ability to recognize their humanity as well as the limits of their power in relation to others. The status of the health provider creates a sense of hierarchy during the communication with the patient. However, even a seasoned doctor like Bob admitted that his belief in God and Jesus Christ as "The" doctor on earth gives him a sense of humility that he relies on when addressing his patients.

> It makes me first of all believe that I am nothing. I am just like every other human being…ummm no matter the level of education I have acquired, I am just the same horizontal relationship with everybody. So I start by making myself very humble. If you make yourself very humble and you create an environment that is conducive for the patient, she will not hide anything from you. So I start by that…so for example if you come from any of our tribes, I may wish to talk to you in your tribe…in your language…or just bring a scenario…maybe a football match…or something to make you understand that you have come to meet somebody who is down to earth to listen to you and that always gives me the leverage for my patients to give me exactly what they have without hiding…

In the current post-colonial era, the use of tribal language is sometimes associated with a lower status and educational level, while the use of colonial languages, such as French or English, is often associated with higher education and status. Thus, in the context of an office visit in a city hospital, Bob's used tribal language to express his attempt to humble himself before his patients by recognizing that despite his expertise, the ultimate healer is Christ and he (Bob) is a human being just like his patients.

Providers also discussed their humility in the face of acute illness as they encountered their patients. Ladia, one of the doctors, noted how humbled she has become working as a doctor:

> Honestly, I cannot speak for others but I think that when you are a human being in contact with illness every day, if you are not humble you have understood nothing to life. What I mean is that while serving you are in contact with suffering every time, it is physical, mental…you see how someone is tortured mentally, you see how someone falls

> apart gradually…sometimes it is acute pains…so while facing this if you do not become humble, telling yourself I can find myself in that position at anytime…if you do not get it…you have not gotten anything at all.

The use of humility shows a recognition of one's place and weakness as a fellow human being and/or one's place in relation to the person with whom one is interacting. This is a value held by both traditional and Christian religions. Within Native religion, however, the showing of humility for people with higher status and expertise is relatively unusual.

Other providers also discussed the need for humility towards patients in admitting limited knowledge in providing diagnosis or in showing the need for further consultation. While this might not constitute an evidence of humility in some Western countries, admittance of limited or no knowledge by a doctor is humbling in countries like Cameroon. Local cultural values define experts, such as doctors, as all knowing and incapable of failure. While doctors discussed and/or acknowledged the importance of humility, patients stated the belief that generally health providers needed to practice this virtue. When providers did show humility, it seemed to come from their propensity to show compassion.

Compassion

Several patients discussed compassion as someone's ability to empathize with the other's suffering and do something about it. References to doctors who were compassionate were just as frequent as references to doctors who were not. However, generally speaking patients stated that most health providers lacked the sufficient compassion towards patients. Fildev, one of the patients, expressed the negative feelings after a provider showed a lack of compassion towards him and his family.

> The doctor was not nice at all. I mean he was a little bit [form of attenuation] impolite…I mean he behaved like someone for whom the only thing that mattered was the money required for consultation and all…and this is a very common example because you see that happening all the time…I mean we no longer know what is the meaning of the "Hippocratic oath" [oath to protect life] that doctors make when they graduate from medical school…because seriously it is really sad…I mean he demanded money….[He said]"if not I am not taking care of you".

Indifference towards patients' serious illnesses while emphasizing the money required for treatment was a recurrent theme that patients stated when they talked about lack of compassion. Patients perceived this as the doctor's failure to address various forms of the health crisis (physical, emotional, financial health crisis), but also as a sign of a lack of compassion from people whose calling requires them to show natural compassion for the sick.

Among the various patient-providers stories that Gran shared, one of them contradicted Fildev's account. Gran's life was saved because one of the doctors on staff showed compassion for him and his mother while Gran expected to die from meningitis.

> I was sick, I was suffering from meningitis, well…[…] when the doctor told my Mom she was extremely afraid. So the doctor provided moral support to Mom saying 'no, this is an illness like any other. He can have "sequelles" [serious brain post-traumatic effects] or he may not…'he comforted me. He was always present [physical as well as emotional presence] until I fully recovered and I did not have any "sequelle."He encouraged me seriously…because it was during a period where a whole lot of young people had died from meningitis here in Cameroon.

Gran's doctor showed compassion when he empathized with both the mother and Gran himself, and he took the time to provide action and words of emotional support. The period when Gran was in the coma with meningitis occurred when numerous young people had died of meningitis in a single night. The illness was swift and rapid and it left people traumatized and fearful. Any other doctor would probably have refrained from giving any hope to Gran's mother after seeing the advanced stage of the illness. This is an example of how this provider's compassion seemed to trigger gratefulness in patients.

Gratefulness

Gratefulness emerged as the act of thanking the provider for services through a face-to-face meeting either when empty handed or with a present. Several doctors referred to grateful patients whom they remembered in a positive way. Coeur shared his experience:

> There was also one time, I was very touched. They brought me a woman who was really serious [seriously sick], but they did not have money. You know that here in Africa for example in remote areas, insurance…it is a little bit like in the U.S.…so the patient has to pay. So when you do not have money, it is difficult. You can be helped but it is difficult. This patient did not have [money]. She was coming from a village. I think she had her identity card [that was it]. We spent everything, I went to the pharmacy free [free of charge for the patient], the hospital [on the hospital's account] and I had also put my care giving, my money on the line. She asked me, "What must I do?" I asked her, "what is your name? Where do you live?" I said "ok, you can go back when you will have money come and pay…" without any guaranty…without anything. She came back later, I could not even recognize her. She said "good morning doctor," I said good morning…[she said] "do you recognize me" I am the one who came here I had this and that…so I would like

> to pay my bill. I said "go to the cashier." She went to the cashier and paid everything. Not only did she pay but she brought thanksgivings [doctor was not clear on whether thanksgivings meant that she brought a token of appreciation or just showed much gratefulness with kind words].

After his account, Coeur stressed the patient's honesty as well as her gratefulness. Considering the patient's low income status, saving up money for reimbursement and paying transportation to come back to the hospital constituted a great sacrifice in addition to bringing tokens of thanksgiving. In ways similar to humility, gratefulness is a religious value relevant to both the Christian religion and to Cameroon Native religious practices in which thanksgiving gifts are brought to ancestors and to other benefactors.

Gratefulness and humility were two religious values relevant to both Christianity and Native religious beliefs that both patients and providers deemed very important in patient-provider encounters. In the case of gratefulness, the patient was usually the one grateful showing thanks for the service provided. However, cases of health providers being grateful for their patients were limited and did not fit with the study's definition of gratefulness as face to face, expressive and tangible. The absence of providers' expressed gratefulness might be related to the limited evidence of expressions of gratefulness from people in positions of power towards the powerless in the traditional culture of the country.

The expression of compassion, which was continually emphasized by patients, related to Christianity but was more limited in Native religious beliefs. While fellow community members are expected to engage in acts of compassion by practicing hospitality (Mbiti, 1991) and other forms of good deeds, heartfelt empathy is often a sign of weakness and naïveté (Rosny, 1985). Because of their immediate need and pain, patients are more likely to expect health providers

will use compassion towards them, while providers might adapt to local cultural values that caution individuals against overt and recurrent compassion towards others. Besides emergence within the context of relationship, religious values also surfaced as a them in my data analysis..

Individual Religious Values

During the interviews participants described personal religious membership or lack thereof as well as they gave examples about how their religious traditions and/or beliefs manifested in various aspects of their lives including health. The following religious values emerged from the participants' accounts and the following were the most recurrent: belief in God, prayer, Christian belief, spiritual intervention, and love.

Belief in God

The interviewees referred to God as the exclusive higher power that could do the impossible. With the exception of one doctor, all the other participants expressed belief in the existence of God as Supreme Being. However, the strength of people's belief in God and the meaning attributed to each participant's relationship with God varied. Rey, one of the doctors, expressed his belief in God in this way.

> Me…I believe in God all the way. Yes, I believe in God a lot. […] First, I have grown up in a religious family. My parents took me to church, they did everything. I was in the choir, I did it all "de maniere tres studieuse" [did it with a very studious heart], but I have to admit that as a seventeen, eighteen-year-old I was just going for the sake of it. The best evangelism I have ever experienced in my life is in medicine. […] This is where I have seen the greatness of God. I saw the limits of human knowledge, and I saw the sparkle [light] that God can bring in order to make a patient well. Sometimes I may want to operate on a patient, I decide to do surgery on him, I get into the surgical unit, I use all of

> my knowledge and then I find out that no, I am stuck. I have nothing left to do[…] and then suddenly I touch something, just like that without any scientific reason […] and the patient comes two days later, I know that I did nothing, [They say] "doctor you have saved my life" and I know I have done nothing. So this story if I tell it in a scientific context [before a scientific audience], they will tell me, you probably ignored something […] I am very critical so seriously I try my best to acknowledge the limits of my knowledge.

Rey's belief in God started as a family tradition when he was younger but as he grew older, he went through a phase where he developed a need for more understanding concerning the reality of God. Later on, years of service as a doctor gave Rey the opportunity to personally witness the existence of God and his works. It seems as if Rey still seeks to integrate his scientific conviction with his strong belief in God.

Sicka, one of the patients, expressed her belief in God by emphasizing the practical ways in which she relates to him:

> I believe in God. The difference between me and someone who believes in…[other religion] is that, it is He [God] who is at the center of my life. I keep Him at the center of my life. That means every decision that I must take, I confide myself in him…so generally when I am about to make a decision, I say "well this is what I am going to do but may the last decision be yours" but me I explain him my will but the last decision is His so I have all my faith in Him.

In her belief in God and the manifestation of his greatness around her, Sicka chooses to relate with God by involving him in her ongoing decision-making process. Sicka does not only believe that God exists and his works are evident, but she has a specific way to relate to God. While

many Native religious beliefs include the existence of a supreme being called God, the interview participants who expressed their belief in God identified as Christians.

Christian Belief

The participants who identified as Christians defined themselves as followers of Jesus Christ, who was born in Jerusalem, died on the cross and was resurrected. Christians related to Christ as the son of God. Some Christians differentiated themselves as Protestant while others conceived Christianity as One. When I asked about his religious beliefs, Revers answered:

> I am a Christian that means I believe in God the Father, the Son and the Holy Spirit. I am a Christian born again.

In his answer, Revers acknowledged the Christian concept of the trinity which assumes that God is three entities in One and that each entity the Father, the Son who is also Jesus and the Holy Spirit are all united. References to each one of these entities emerged in Christians' stories of spiritual intervention, prayer and spiritual health. While none of the participants clearly identified as a Native religious believer, these beliefs were latent and sometimes manifest in the providers and patients' discourses. For example, profound fear of death tied to Native religious beliefs was one of the emergent but latent native beliefs.

Fear of Death

The human survival instinct is a natural phenomenon, which makes fear of death just as natural, but the fear of death held by Cameroonians is unique to this region's Native religious beliefs. The extent of the fear is partially justified by the fact that loved ones' lives represent a responsibility for family members and meeting the needs of loved ones produces the inherent meaning of community members' lives. Once loved ones die, they take away with them the survivor's life purpose as well as their cherished social, emotional and physical support. The

death of loved ones often means the emotional and social death of the survivor. I experiences some of Norman's agony as he painfully recalled the prospect of losing his mother while his father was dying of an excruciating illness:

> So another story, my mother is sick so I take her to the hospital. I come back one day, I read the notebook by her hospital bed, I do not know how you call that…I read cancer of the uterus. I lost my mind, I started crying [taboo for a man in Cameroonian culture] […]I came I saw a notebook since I am very curious, I took it and read…and when I read I was like what am I seeing? Since she [mother] herself saw me crying she was taken with panic…but I left the room. She [mother] insisted that I tell her why I was crying…I went out and told her I really did not know, I cannot explain anything [the mother asked] "What did the doctor say? Am I going to die?" "I cannot tell you, you need to rest. I am going to go out." In the hallway he [doctor] saw me. He approached me and said "Why are you crying?" I said I read something that…something that I was not supposed to [as forbidden to my eyes] read. So here I am totally lost, my father is in such a state [dying] and my mother in this one, […] this is a tragedy.

Norman's despair was profound. He used the expression losing his mind but in the context of his story the expression was closer to reality that one might think. Stories of survivors literally losing control of their minds and jumping into loved one's graves are often told in Cameroon. Within the context of Native religion, death is a dark, swift, ruthless enemy against whom believers are left powerless.

Because of their deep-seated fear of death in the culture, most patients expect health providers to act as intercessors on the behalf of patients, to save them from death and its connotations in Native religion. Such expectations are relevant to Native religious beliefs where

traditional healers attempt to spiritually intercede for the victims of spells and eventually help prevent death (Rosny, 1985). It appears that some health providers (Rey) have placed self-expectations of protecting patients from the traditional enemy that is death, subconsciously enacting their traditional Native beliefs.

From a Christian perspective, death is only a passage to greater reality that is life with Christ, therefore death is only separation from those who do not believe. While Christians' beliefs about death might be known to some of the Christian participants, for others there exists an inner tension between deep-seated cultural knowledge and Christian beliefs about death. While facing the prospect of death or milder adversities, Christian participants reported using prayer.

Prayer

Prayer was often described as an audible or non-audible conversation with God. In several cases prayers were request based, meaning that the person engaging in prayer was asking God for something. In other instances, the person in prayer was receiving instructions from God. Prayer is a concept that is relevant to both Christianity and Native religion; however, participants only mentioned prayer in the context of Christianity. Coeur, one of the doctors, explains the consistency of prayer as means to ask for guidance in his life:

> Christian principles…I mean I used to pray before…I used to do it even before medical school, it is the same thing that I continue to do. When I want to do something I pray. If I want to make an important and serious decision I pray. It does not change anything whether I am a doctor or not.

Coeur stressed the fact that though prayer was a constant in his life, it was also personal and private. He kept his belief in God and prayer silent in his encounters with patients unless the patients requested spiritual support.

Emil, one of the patients, indirectly discussed the concept of prayer as a means for him to receive instruction and healing from God:

> I tell myself that Christ who is in me […] allows me to live a life always victorious because of his presence in me, I understand that his presence […] in me strengthens me, to the point where I always say that if I have an ailment in me, I will get better no matter what if God so desires because I know that He is capable of all things. All it takes is for Him to say, "ok […] today you will be healed."He can lead me to…he can even give me a revelation saying "take [eat or drink] this herb, or the bark of this tree," and I receive full healing.

Emil's contribution expressed syncretism in his beliefs about the joint role of Christian and Native religious viewpoints. In Native religious beliefs, sometimes healers use natural remedies, such as herbs and bark of trees as prescribed treatment; however, some healers also add native spiritual activity to address their patients' ailment. In common with several other patients, Emil seems to believe in the resourcefulness of his traditional environment and culture as long as Christ is the spiritual power guiding the use of these resources. According to Emil and other God-fearing participants, when God is leading one's life, spiritual interventions are miraculous.

Spiritual Intervention

While facing adversity, failure of human wisdom and capacity, some of the doctor and patient interviewees referred to God as a source of help that human knowledge and power could

not provide. God's help and provisions during trying times was labeled as spiritual intervention, a concept relevant to both Christian and Native religious beliefs. Most patients who discussed spiritual interventions said that they came from Christ. Sam, one of the doctors, told a story about her experience of God's spiritual intervention at work:

> I will give another example, there was a day, the obstetrician told me that ooo you see by nine…because pediatricians [like me] are suppose to be there to receive babies when there is a caesarian section so I was told "look if this woman does not give birth by now we [health care staff] will have a caesarian section." I said "please can you wait till eleven?" So I went into the labor ward and I prayed with the woman, I told her to keep praying […] I honestly completely forgot [about the whole thing] […] I was busy consulting my patients so later maybe a day or two later. …"So what happened to that women?" they said she gave birth at a quarter to eleven.

Because of reasons that she did not mention during the interview, Sam was concerned about giving the patient a cesarean section. Considering the state of Cameroon as a developing country, a cesarean section might have been risky for the pregnant patient. So it is not surprising that Sam understood the patient's delivery of the child fifteen minutes before the appointed time of the cesarean section as a divine intervention from God.

Kam, one of the patients, also shared a personal story about how he received spiritual intervention after praying with a religious leader concerning a form of illness.

> One day I was sick…because that was an illness, I went through the same end of high school exam [GED] for four years. The men of this world had said that I would never get my exam. In my studies I was not that bad because even with intuition…when you do something multiple times [you finally get it]… I could not understand how every time

> that I go to take the exam I failed. So one day a friend, a brother told me but seriously your situation is worrisome to us. Every year you go [take the exam] […] I know somewhere where I will take you, if you believe; I think this year you will not fail. He took me to a community [Christian religious community]. The pastor who was there took care of me only prayers…fasting…[…] that year I was no longer going to school because I had given up saying that I am no longer [doing this going to school thing]… I am already ashamed…because my […] friend was already doing his bachelor degree….so how…we started junior high together…so I gave up. So I took the exam [while consulting with this pastor] as "candidat libre" [student not attending school].[…] The pastor said that if…because he knows that the God that he serves is alive, if that year I did not pass the exam he would remove his minister's gown [stop being a pastor][…] The only condition that I was given [the question I was asked] was "do you believe that the One that you have never seen who has given his life for humankind…that he can do something in your life?" I said yes. That is how I passed my exam.

It is important to provide some context to Kam's situation. Because education is highly valued in Cameroon, some local Cameroonians view repeated failure in school as an illness caused by a jealous or mean-spirited member of the community. The assumption is that the mean spirited person would have consulted a witchdoctor in order to cast a spell on the victim. Consequently, some Cameroonians who hold Native religious beliefs do consult witchdoctors for protection and for success in their educational endeavors. In this context, it is not surprising for Kam to perceive his repeated failure of this exam as illness and the answer to his prayers, as part of God's spiritual intervention against forms of metaphysical oppression. In the process of restoration to educational success, Kam experienced more love for God.

Love

The subtheme of love emerged in a subtle way, but it was nonetheless present. While discussing patient-provider encounters filled with obstacles and/or pleasant surprises, participants' value for love was latent but sometimes expressed. Love here seemed to be the ability to accept the other as fallible and the motivation to do well toward another person despite their failures. The previous definition of love is relevant in Christianity but not in Cameroonian Native religious beliefs because Christianity discourages human retaliation and acknowledges grace while Native religion does not. Krist, one of the Cameroonian patients, suggested:

> So what I would say…It is necessary for us to learn to know each other and accept each other as we are…even though sometimes, other people's behavior frustrates us and makes us angry…yes…we need to learn that…to accept others as they are in love. Because for me this is how we will be able to help them understand that they have a problem. So the way you correct someone even if they have frustrated you means a lot to me, really it counts a lot. So if I am a doctor and maybe my patient does something that made me mad, I will try to understand why the patient acted that way, is there something that lead him to act that way, is that thing [trigger] caused by me.

Krist's point about love clearly articulated the desire and need expressed latently in patients' complaints and observations in reference to doctors' relationships with patients: patients express a hope to be loved by the health provider during the encounter. However, even more subtle was provider's hope to be loved by their patients. This hope to be loved came in various forms, a need for understanding that was part of the story told by Queen about a patient whose face was threatened.. Thus, the expressed need to love and be loved is common both to patients and doctors.

Krist continued:

> I believe that to be able to accept the other the way he/she is with his/her behavior it takes love. This is why Christ says: “”love your neighbor as yourself. […] There are some reactions that others have that maybe we have often…you see and when someone else has that [same] reaction, it is easily irritating but [you get irritated] without knowing that you probably did the same thing [elsewhere] and irritated someone else…you see […] As human beings we cannot live perfectly, so if we take this path [accepting and loving] with sincerity...I believe we will…God will help us because it is not by human power […] It is by God’s power that we will be able to make it.

Krist acknowledged the difficulties of showing love especially in a strenuous context such as the health care setting; however, he claimed that for him God constitutes the help that each individual needs in order to practice love.

The embedded nature of health beliefs shows both a conscious or unconscious manifestation of these beliefs during interactions. Thus in the present chapter, I explored the communication between providers and patients in light of the internal cultural struggle analyzed in chapter 4. I utilized a narrative analysis of themes and subthemes from 12 patients’ and 10 providers’ interviews. My thematic analysis of this data yielded several general categories and several subcategories. The data analyzed in this chapter answers RQ 3 through RQ 5 in reference to salient features of communication. I divided the data analysis into beliefs about patient-provider communication, dialogue and religious values. Beliefs about patient-provider communication, emergent features of dialogue during encounters and religious values suggested that participants’ salient and embedded cultural beliefs do influence their communication in patient-provider interaction as well as their expectations in patient-provider encounters. Findings

suggest that Cameroonian participants approach patient-provider communication as an exchange that includes the patients' and health providers' sense of responsibility and patients' and providers' participation where health providers acknowledge cultural, self- and patients' expectations. Three features of dialogue were identified as part of the patient-provider encounters in the Cameroonian context mainly: listening, time for the other and treatment as family. Finally, my data showed that religious values clearly influenced health encounters causing participants to practice or desire humility, compassion, and gratefulness.

CHAPTER 6:

RESEARCH IMPLICATIONS

In this chapter, I interpret the data analysis according to each of the questions, starting with RQ1 and concluding with RQ5. The collection of accounts conducted through warm and convivial in depth interviews constituted a powerful gathering tool for crafting the untold stories of the Cameroonian patient-provider encounters. The present chapter will render part of this unique analysis by focusing on the ways in which assumptions about the Western medical model intersect with assumptions of the traditional native culture: the Cameroonian patients' and providers' conceptualization of health and illness, the influence of Native and Christian religious beliefs on patients and providers practices, the ways in which patients' and providers' interactions incorporate narrative and dialogue, and the differences between how patients and providers view the quality or ethical aspects of their health related interactions. My interpretations also relate the data analysis to the previous literature review..

Beliefs about the Western Medical Model and Native Culture

My first question sought answers about the connections between the Western and traditional models of health and healing. The question in RQ1 is: how do the assumptions of the Western medical model intersect with those of the native culture in patient-provider interactions? The Western medical model is currently used as the "officially recognized" health care approach within the context of contemporary Cameroon. Thus, while discussing with the patient and provider participants about health crisis, references to "going to the hospital" were often part of the general health discourse. Cameroonian hospitals rely on a Western medical model that is a biomedical, scientific and reductionist approach to illness that focuses primarily on the body (Fongwa, 2001; Hahn & Kleinman, 1983). Hahn and Kleinman note that biomedical

practitioners believe that their domain is separate from religion, morality, politics and social organizations. Before the Western medical model of health care was introduced into this region of Africa, Cameroonians' native cultural approaches to health were primarily holistic, attending to the individual as a whole being, including the individual's spirituality (Appiah-kubi, 1975; Mbiti, 1970; Helman, 2007). Despite the clear divide between the reductionist assumptions of the Western medical model and the holistic assumptions of the native cultural approaches to health, participants' interviews revealed an intersection between the two approaches: biomedicine was one of the approaches and traditional native holistic medicine was the other.

While neither the doctor nor the patient participants clearly identified with native cultural approaches, their choices, actions and suggestions provided evidence that Native beliefs and the cultural assumptions that underlie them are important to health care in Cameroon. Several doctors and patients made references to biomedicine as one of the options patients could use when their health seemed to be faltering. However, if biomedicine does not address the issues and if the patients feel that their health problems pertained to another dimension of their being, they sought other types of health remedies and used them. Queen, one of the doctors, noted: "So if a person feels like his problem is not medical it is something else, another dimension, the person is free to go and see whomever he wants to see."

The idea here is that biomedicine addresses a dimension of the person's being, and if biomedicine is not working then the patient's ailment is located in another dimension of one's being even though the illness seems to manifest itself physiologically. In other words, biomedicine is only one of the various strategies that a patient embracing a native holistic approach could use, specifically when addressing the patients' physiological dimension.

Since biomedicine allows for native holistic approaches to healing, the basic assumptions of the Western biomedical model are partially preserved. The reductionist emphasis on the person's body and the exclusion of spirituality can still support the function of a multidimensional native holistic approach. In this case, biomedical practitioners are not required to address spirituality (Hahn & Kleinman, 1983), but they can refer the patient to another source that will address the spiritual being of the patient and provide a different type of healing.

One the patterns observed and explained by patient participants is that, culturally, once one becomes sick one goes to doctor for treatment; if the doctor is not capable of dealing with the illness that at first is manifest in physiological symptoms, then the patient seeks a spiritual authority, be it a Christian pastor or a traditional religious doctor (Appiah- Kubi, 1975). In some instances the biomedical doctors even encouraged patients to understand their ailment from a spiritual dimension instead of the physiological one. The following excerpt from Rey, one of the doctors, illustrates this point:

> So the doctor in the other town told her, listen I have never seen a case of Rabira C [pseudonym for the illness] last so long. Your doctor [referring to Rey], you can tell him to write you a recommendation for days off to go see a traditional doctor.

The doctor who referred the patient to a traditional doctor showed her holistic approach to medicine despite her biomedical training. However, the fact that she refrained from providing the patient with a leave of absence to go see a traditional doctor suggests the existence of an internal struggle between the doctor's biomedical convictions and training (Conrad, 1988) and her belief in the practice of holistic care. Several participants that were doctors showed openness to holistic approaches to healing at the same time as they expressed reservations towards promoting them. This finding is consistent with research pertaining to doctors' biomedical training that consists in

improving patients' physical health and preventing diseases by biomedical treatments (Bonsteel, 1997; Conrad 1988).

Thus, approaching health care from a Westernized and biomedical standpoint provides doctors with status and power as biomedical professionals; however, more than half of the doctors that I interviewed for my research and most of the patient interviewees seemed to have made partial sense of the connections between the biomedical and holistic dichotomy, by approaching Westernized medicine as a primary strategy and holistic Native medicine as a secondary strategy to address the multidimensional human being and their needs for healing. Despite the apparent domination of the Western biomedical model, native cultural and holistic approaches to health seem to complement biomedicine as a strategy to achieve part of its overarching goal, the health of the whole being.

Contemporary Conceptualizations of Health

My second questions sought answers about patients' and providers' conceptualizations of health. The question in RQ2 is: How do Cameroonian providers and patients conceptualize health and illness? The exploration of Cameroonian participant's Native religious beliefs pertaining to health provides knowledge concerning their conceptualizations of health. In one of the French training manuals designed to prepare health providers for national entrance exams, (Gassier, 2000) reports the "OMS" (World Health Organization) definition for health as a state of physical, psychological and social well being. Even though this definition is inclusive of more than just the physiological dimension of the individual, it does not correspond to the various dimensions of health identified by participants in the study. Cameroonian participants' conceptualization of health were in line with Mbiti's (1970) report on traditional African's understanding of health as more than just physiological, psychological and social (Gassier,

2000). Cameroonian participants conceptualized health and illness as physical, emotional, moral, financial and spiritual.

Physical Health

For most patient and provider interviewees, the first reference to health was physiological, meaning that for them being in good health was having a body that is free of pain, a body that functions relatively well. However, participants also emphasized that being in good physiological health did not mean having a perfectly healthy body. One was physically healthy, if he or she was capable of using the body to perform daily activities freely. Thus, unlike some approaches to health that promote the perfect body and perfect health, the participants' concept of physical health was that good physical health was relative and functional. Implications for such conceptualizations of physical health are that patients admitted going to the doctor only when the physical ailment had reached a critical point, and when treatment was needed immediately. This probably explains some of the frustrations experienced by participants waiting for diagnosis and treatment prior to patient-provider encounters. Most providers and patients started by defining health as physiological. Patients like Kam even mentioned said that health is physiological in its "etymological sense." However, all the participants proceeded to identify other forms of health equally important for the individual's overall well being.

Moral Health

Cameroon participants, especially doctors, also defined health as moral. Participants explained that moral health was a state of psychological and social well being related to one's sense of duty. Precisely, moral health was the sense of freedom from stress that one may experience when they have fulfilled their duty toward their community. While one might readily associate moral health to psychosocial health, it is important to note that Rey's choice of the term

"moral" health captures a health concept relevant to the Cameroonian communal reality (Moemeka, 1996; Mbiti, 1970). As Moemeka notes, Africans' reality revolves around their communities and failure to provide for members of one's immediate community, as some participants explained, is as failure for the self. Thus, such forms of failure result in profound and traumatic stress for the individual.

References to conceptualizations of health as moral indicate that some providers who perceive patients as community members experience a lack of moral health when they fail to provide the necessary care for their patients. One of the health providers shared his turmoil when facing such devastating situations. Fongwa's (2001) account pertains to the weakness of the Cameroonian health care system to provide timely care exposed some the critical issues that challenge health care providers in their ability to properly care for Cameroonian patients. These socio-economic challenges have the propensity to impede the way that providers like Rey address the overall moral health of patients. Therefore, in a context where health is conceptualized as moral, systemic socio-economic challenges constitute a source of illness (a perceived professional incompetence) for some health providers, affecting them mentally and even emotionally.

Emotional Health

Cameroonian patients and doctors also conceptualized health as emotional, defining health as being in a good mood and feeling good about themselves and their health. While participants did not clearly elaborate on this conceptualization of health, some of the examples were that emotional health pertained to the feelings that people experienced when they felt loved, valued, secure and content. References to community and social support were often mentioned in tandem with emotional health. Thus, based on the participants' accounts, emotional health was a

psychological feeling of closeness to other members of the immediate family as well as the extended community. Connections between conceptualizations of health as emotional and related to the person's place in the community reiterate the important influence of the Cameroonian participant's community on their health (Meomeka, 1996). In other words, the health of participants is closely tied to the state of their communities and their communities' ability to care for them emotionally. In addition to the emotional support from the community, some of the participants talked about turning to spiritual sources in order to experience well being.

Spiritual Health

A number of doctors and patients shared their conceptualizations of health as spiritual, which is the experience of a sense of inner peace resulting from one's right standing or security in the spirit world. Security or well being in the spirit world was often articulated by interviewees, and they explained this as talking to God through prayer and enjoying his protection from spiritual evil forces. For people living in a non-African context, the notion of a spiritual covering may sound superfluous and confusing, because unlike most health providers and patients in some other parts of the world, Africans believe in a metaphysical world different from the physical world. As Rosny (1985) brilliantly noted, within the context of traditional Cameroon conflict and violence is framed spiritually so that social order can be easily managed. Therefore, the spiritual world is a violent place where everyone is in need of some form of protection in order to become spiritually healthy. While experiencing attacks from the spirit of fear, interviewee Kloklo went to God in prayer for spiritual intervention and protection, after which her spiritual health was restored because attacks from the spirit of fear ceased and peace was restored to her. Conceptualizations of health as spiritual show that even though some of the participants identify as Christian, they understand the world through their native cultural

paradigm. Because Christianity emphasizes the existence and the importance of spiritual reality, the existence of good and evil spirit beings, participants who self identify as Christians were able to articulate their concept of spiritual health referring to God as their spiritual healer and protector. For example, Emil noted:

> I tell myself that Christ who is in me […] allows me to live a life always victorious because of his presence in me, I understand that his presence […] in me strengthens me, to the point where I always say that if I have an ailment in me, I will get better no matter what if God so desires because I know that He is capable of all things. All it takes is for Him to say, "ok […] today you will be healed." He can lead me to…he can even give me a revelation saying "take [eat or drink] this herb, or the bark of this tree," and I receive full healing.

Emil's quotation illustrates how Cameroonian participants have incorporated Christianity as part of their understanding of metaphysical Cameroonian culture, so that God who is spirit can be their protector and provider of health. The concept of God as health provider in African traditional culture is also articulated by Mbiti (1970; 1991) when he explains that in times of catastrophe or other forms of need, traditional Africans turn to God for provisions of protection or help.

Conceptualizations of health as spiritual have critical implications within the Cameroonian context. Patients and providers' interviews showed that although they made clear and profound references to their spiritual health, they lacked the vocabulary to clearly articulate this part of their spiritual reality. Instead of talking of spiritual "health," some participants like Revers talked about "spiritual well being." While the use of "well being" for explaining spiritual health is legitimate and explicit, it denies the official and recognized status that physical "health"

usually carries. As Giroux (1993) suggests, the use of language is a powerful tool to restore marginal discourses to their merited status. The process of officially reintroducing spiritual well being as a form of health would bring more attention to the spiritual needs of patients like Rey and both facilitate and legitimize discussions about spiritual health. Further discussions between providers and patients about spiritual health might positively affect some of the patients' anxieties regarding financial health.

Financial Health

Patient and provider participants made numerous references to financial health. Ladia, one of the doctors, conceptualized financial health this way:

> Financial health for me, I believe that someone who has financial health is able to take care of his needs that means he can go to the hospital, pay for his consultation, pay for his medicine, pay for his health exams, at the house he can pay for his food for the day. I mean the person is sure to afford a daily meal every day, sure to afford his medicine, sure to afford his transportation…that is what I am talking about. I am not talking about having a whole lot of money in your bank account but having the basic financial minimum to live right.

Ladia's conceptualization of financial health was consistent with other participants' understanding of financial well being as a state in which one enjoys enough financial security to be protected from social ills and other forms of disasters that might affect their financial status and ultimately other parts of their health. Mbiti (1991) explains that in traditional African culture, people rely on forms of medicine to protect their financial assets. While some go to traditional medicine men for such medicine, others turn to God for protection of their goods or for good fortune. Thus financial health can be compared to financial power, but also to the well

being experienced by people from their possessions and success. Kam, one of the participants, mentioned his repeated failure in education as a form of illness. In a society where education is synonymous with better job opportunities and improved financial income, Kam's conceptualization of health is in line with Mbiti's (1991) reference to health as prosperity. In other words financial health was evident by the extent to which the participants felt they were prosperous, could function normally, succeed in their various endeavors and enjoy a healthy growth in society.

Unfortunately, the state of financial economic crisis plaguing the Cameroonian nation influences participants' ability to be prosperous. One of the doctors admitted that his level of prosperity and ability to serve others (moral health) was highly impacted by the financial strain experienced nationally. Therefore, financial health is a form of health that can be extended to the community, and lack of financial health within a large community affects the financial health of its members as well as other parts of their health. In Cameroon, the financial health must be addressed both at the systemic level then at the individual level if the health system is to flourish.

At the individual level, some participants who are doctors talked about ways in which they gauged their patients' financial health and supported it by prescribing physiological medicine that would not further endanger the patients financially. Other doctors such as Coeur researched and used funds available in health care institutions in order to support and protect the financial health of patients whose financial health was precarious. The creation of systemic infrastructures that facilitate supportive measures towards patients' poor financial health is of the essence for providers to improve patients' health.

Influences of Native and Christian Religious Beliefs

My research attempted to answer questions about the influence of Native and Christian religious beliefs on health. My research question RQ3 is: how does Cameroonian culture, especially Native and Christian religious beliefs, influence the beliefs and practices of providers and patients? After the verbal/physical abuse and killing of several witch doctors that threatened missionary work (Foussouo, 2008), organized traditional religious societies became marginal and often secret. As a consequence of such historical facts, believers and practitioners of Native religious traditions also became discreet about labeling their beliefs as traditionally religious. As a result, some Native religious beliefs remained secret within the general Cameroonian culture, so that some people continued to hold traditional beliefs and allowed them to influence their lives without self identifying as Native religious believers.

Participants' accounts supported this reality. While some of the participants identified as non-religious Native believers, their worldview was illustrative of some traditional beliefs. Droogers (2005) explains such phenomenon as forms of syncretism where religious believers depend on more than one religious source for sense making and problem solving, even though they might not do so intentionally or openly. To add to the confusion, some Christians believe that Christianity is defined within the context in which it is practiced; therefore native cultural beliefs are the mold in which Christianity should be incorporated (Mamia & Massage, 1999). Several participants' accounts suggested that consciously or not, the participants did believe in Christ but also incorporated these beliefs along with those they adopted from their Native religious culture. Native and Christian religious beliefs influenced both patients' and providers' belief in God, prayer, Christianity, spiritual interventions, fear of death and love. The beliefs acquired from Native and Christian religious beliefs lead the participants to practice humility, gratefulness and compassion towards other community members, especially in the context of

health care. Looking at each of the acquired beliefs and simultaneously discussing the practices they inform helps others to understand the participants' religious values and their implications for health care and health interactions.

God and Prayer

As mentioned earlier, some of the religious beliefs acquired by patient and provider participants contain both Christianity and Native religious beliefs about God and prayer. As Mbiti (1991, 1970) suggested, traditional African communities believe in God as a supreme being who could choose to grant their requests for protection, provision and other needs. Some provider and patient participants admitted to their belief in God and their use of prayer as a way to communicate with God and receive several benefits including guidance. Rey, one of the doctors who identified as Christian, stated:

> But as far as I am concerned if I have any advice to give…always to my patients, I tell you to pray to God. I might not send you to your spiritual leader because I do not recall having told anyone go and see your pastor or else but I would say listen pray…the time has come.

Rey's belief in God was articulated throughout his interview as illustrated through this excerpt. As a mere doctor and fallible human being, Rey humbly admitted the boundaries of his power to his patients by referring them to God who he believes can do all things, being humble. In his study of traditional African community morals, Mbiti (1991) found that politeness, showing of respect and being honest and truthful, are considered factors of good moral behavior. The practice of these behaviors shows evidence of humility, that is, the ability to recognize one's place and the limits of one's power. Humility is a quality that is relevant not only to traditional Native religious culture but also to Christianity. In Christian sacred texts, in the book of Matthew

23: 12, Jesus Christ is quoted saying: "And whoever exalts himself will be humbled, and he who humbles himself will be exalted." Thus, humility is a quality borrowed from Scripture that is encouraged both by Christianity and Native religion.

Participants deemed the practice of humility not only consistent with both Christian and native religious beliefs, but also as helpful in bridging the gap between community members, including providers and patients. Thus, revisions to health providers' training and curriculum should include humility as a critical element of patient-provider communication, an approach to knowledge and practice that might considerably reduce the gap existing between patients and providers in the Cameroonian context. The revision of the health providers' curriculum is a practical and feasible endeavor, which has been adopted in Western contexts (Bri et al., 2007), and could easily be incorporated into training for Cameroonian providers.

Christianity

Besides belief in God and prayer in general, many participants identified themselves specifically as Christians. When I asked them to explain its meaning, some referred back to denominational divisions, specifying their Christian denominations, while others such as Sicka explained that they were Christians because they had committed their lives to Christ (Foussouo, 2008). Valuing Christianity and identifying with Christ suggests that participants that self identified as Christians try to practice humility, compassion and gratefulness.

However, even though they acknowledged these behaviors as desirable, they did not always put all of these Christian values into practice. For instance, when Leba, one of the Christian patients, had a disagreement with the nurse, he told me that he showed a lack of humility in his response to her. While sharing this account during the interview, he recognized that he could have reacted differently but explained that he has a temper. Based on this account

of how the nurse approached him disrespectfully and impatiently; however, a different response from Leba might have changed the nature of the encounter. Therefore, while some participants identified as Christians and aspired to Christian beliefs, the practice of these beliefs was often challenged by the difficulty and by their own personal emotions in the contexts in which they found themselves. When the health provider showed genuine care, Christian patients admitted feeling much gratefulness towards the providers. Norman emphasized the fact that despite the numerous disagreeable patient-provider encounters that he had experienced, when a provider showed genuine care and his health was restored, he would go back and express his gratitude to providers who gave care to him in a compassionate way. According to the responses from interviewees, the perseverant practice of Christian principles such as humility, compassion and gratefulness by patients towards health providers also was a catalytic event that could encourage health providers to be more humble.

From the accounts of other Christians, especially doctors, the practice of Christian principles such as humility, compassion or gratefulness seemed more recurrent. For example, Bob who identified as Christian leader, shared how being a believer in Christ humbles him during health encounters, when he stated:

> [The fact that he depends on God] makes me first of all believe that I am nothing. I am just like every other human being…ummm no matter the level of education I have acquired; I am just the same horizontal relationship with everybody. So I start by making myself very humble. If you make yourself very humble and you create an environment that is conducive for the patient, she will not hide anything from you. So I start by that…so for example if you come from any of our tribes, I may wish to talk to you in your tribe…in your language…or just bring a scenario…maybe a football match…or

something to make you understand that you have come to meet somebody who is down to earth to listen to you.

Bob admitted that being a believer in God and depending on God reminded him that he was just like any other human being in need of God's help and guidance; in that respect he was not very different from his patients, despite his education. The fact that Christian doctors seemed best able to identify and elaborate on their practice of Christian beliefs such as humility made sense to Christian patients who connected the doctors' greater amount of experience with situations that demanded application of this Christian principles. Another interpretation is that patients are always required to be humble, so the practice of humility during the encounter is the norm, thus less salient to them than to doctors.

For the most part Christian patients' accounts of patient-provider encounters pointed to the lack of the practice of compassion and humility by Cameroonian health providers. While this might be true, Mamia & Massaga (1999) invite Christians to "offer up actions in the name of the gospel. These actions are made meaningful in relations to the whole plan [of God] rather than themselves" (p. 244). The invitation is not limited to doctors but extended to all Christians; therefore doctors and patients who identify as Christians should strive to sacrificially behave according to their Christian religious beliefs in order to fulfill their duty to provide and "watch over health" and "watch over human relations" (p. 249). If Christian providers and patients asked for God's help and took it upon themselves to work toward an authentic application of their beliefs, patient-provider encounters in Cameroon could achieve the fruits of selflessness that Mamia and Massaga envision for Christian providers and patients. This idealized concept of health care based on Christian values and practices could result in a better relationship with God, that is, a greater spiritual health as well as more loving and meaningful relationships with the

neighbor (Kierkegaard, 1995; Mamia & Massaga, 1999). This idealized vision presents a standard for ethical provider and patient interactions that has the potential to improve the quality of health care, but it is also a standard that is difficult to achieve.

Spiritual Intervention

According to Mbiti (1991), in the African traditional context spiritual interventions are phenomena that occur when traditional religious believers offer prayer to spirit beings in hopes of getting their physical and psychological needs met. Cameroonian patients and doctors continue to believe in spiritual interventions even when they consult different spirits from before to request the help needed. An informant interview with a family member revealed that as a people Cameroonians continue to live according to their native ways. For example, while facing challenges such as serious illnesses, most Cameroonians are likely to go to a doctor, but if the diagnosis is not conclusive and the patients are still in pain, they turn to the metaphysical world to seek answers and receive spiritual interventions from non-medical powers. While Christians often turn to God, Cameroonians who believe in the power of other spirit beings sometimes go to a witch doctor for a spiritual intervention. The informant's detailed account concurred with that of other participants' interviews, specifically with doctors' interviews. Sam, one of the doctors, shared a story where she asked for spiritual intervention for one of her patients:

> I will give another example there was a day, the obstetrician told me that ooo you see by nine…because pediatricians [like me] are suppose to be there to receive babies when there is a caesarian section so I was told "look if this woman does not give birth by now we [health care staff] will have a caesarian section. "I said please can you wait till eleven?" So I went into the labor ward and I prayed with the woman, I told her to keep praying […] I honestly completely forgot [about the whole thing] […] I was busy

consulting my patients so later maybe a day or two later …"so what happen to that women?" they said she gave birth at a quarter to eleven.

Sam's patient was running the risk of getting a Caesarian section so she turned to the spirit world asking God for a spiritual intervention for her patient and her request was granted. The implications of Sam's action are profound. First, Sam's choice to pray for her patient shows that she practiced compassion towards the patient. She could have ignored the statement of the other health provider who was planning to engage in the surgical procedure, but instead she decided to watch for the patient's health (Mamia & Massaga, 1999). Second, the outcome of Sam's compassion and prayer suggests that spiritual interventions are ways in which health providers can care for their patients in ways that have meaning for both. During her interview, Sam shared that she only prays for spiritual intervention for her patients openly if they are open to it. This was the case for the woman who was pregnant; in fact, the woman continued to pray after Sam left.

Akoko (2007) also calls attention to Cameroonian patients' need for spiritual interventions based on their cultural native background and also to some churches' provisions for that need through changes in worship style and healing prayers. Patient participants' accounts, like those of both Kloklo and Kam, illustrated their need for spiritual interventions when other forms of help like that provided by Westernized medicine would not work. Considering the great financial strains experienced in Cameroon, by those like Sam, some providers' attempt to gauge their patients' needs for spiritual interventions and mirror the views of church leaders that acts of compassion are necessary in health care encounters and settings. Spiritual interventions are tools that Cameroonians use against the worst enemy in African traditional culture that is, death (Mbiti, 1991).

Fear of Death

Fear of death is a concept that Mbiti (1991) emphasizes while discussing African traditional cultures and one cannot overstate the phenomenon as it is understood in the current Cameroonian context. Even though few participants actually articulated their fear of death, especially for patient participants, this fear seemed to be an overshadowing presence in their accounts. The helplessness and the despair accompanying each negative story in which a patient was on the brink of death and was left without treatment provide glimpses of the subconscious and intense fear of death that plagues at least some Cameroonians today.

Kloklo shared her story about her fear and later in the interview she explained that this fear centered on death.

> Because sometimes I see…I dream like that...I am dreaming and then I see coffins, I see dead bodies, I see dead bodies. When I wake up or when I am sleeping…I picture my mother in a coffin…yes if not my mother, my dad, I see the picture on his tomb and everything…I felt helpless.

In another cultural context, Kloklo's account would probably mean something different, but in the context of the Cameroonian culture her experience of fear is an intense emotion familiar to several other Cameroonians. While relating the story of his mother's acute illness, the same air of despair and helplessness against death weighed on every word Norman used as he related the story. Death is perceived as a mystical enemy just as Mbiti (1991) describes it, an enemy constantly snatching loved ones and community members without warning or excuses. This dread of death is deeply seated in Cameroonians' cultural consciousness, and it surfaces when community members, such as patient participants in my study, see other community members succumb after seemingly insensitive health providers fail to give them the care they want and

need. In traditional Native religious practices, the purpose of traditional religious healers is to protect the community from the enemy that is death (Rosny, 1985). Thus, patient participants' expectation towards doctors is to use compassion and sacrificially protect the patients from their enemy, death. Gran's gratefulness towards the compassionate doctor who saved his life illustrates the point:

> I was sick, I was suffering from meningitis, well…[…] when the doctor told my Mom she was extremely afraid. So the doctor provided moral support to Mom saying 'no, this is an illness like any other. He can have "sequelles" [serious brain post-traumatic effects] or he may not…have comforted me. He was always present [physical as well as emotional presence] until I fully recovered and I did not have any "sequelle."He encouraged me seriously…because it was during a period where a whole lot of young people had died from meningitis here in Cameroon.

As mentioned earlier, Gran suffered from an illness that had taken the lives of many young Cameroonian adults over a very short period of time. His mother was in total despair, but this doctor used compassion towards her and her son and comforted the family and gave them hope and life. In light of the deeply seated fear of death that plagues patients such as those who were interviewed during the project, it is important for Cameroonian health providers to understand the critical role of compassion in caring for patients. Because the concept of compassion does not always apply to native Cameroonian cultures, it is important to Cameroonians holding native cultural beliefs to reframe the concept of compassion towards others to include acts of service towards the community (Mamia & Massaga, 1999; Mbiti, 1991). While fear of death originates from African and Cameroonian traditional native culture, Christian beliefs address the issue of fear of death through the notion of love.

Love

Within the context of Christian beliefs, love is described as a sacrificial disposition towards others in which a person seeks to address the interests of others before his or her own. This is the understanding that Krist, a Christian patient, explained while emphasizing the need for love in the patient-provider encounter. He stated:

> I believe that to be able to accept the other the way he/she is with his/her behavior it takes love. This is why Christ says: "love your neighbor as yourself […]." As human beings we cannot live perfectly, so if we take this path [accepting and loving] with sincerity....I believe we will….God will help us because it is not by human power. […].It is by God's power that we will be able to make it.

Krist's reference to the need for people to cultivate genuine acceptance and forgiveness in love is a powerful concept in a financially limited health care system where patients are forced to wait until the last minute to show up to the hospital desperate to find some form of protection from death. Clearly, in such a state patients are unable to understand the infrastructural constraints of the Cameroonian health care system, and the health providers who are pain free cannot always relate to the challenges of their patients. Kryst's belief in love reemphasizes the importance of showing compassion and its affect on patients.

Compassion can also be practiced by patients towards their health providers. Accounts of health providers suggested that even though they refrain from sharing it with their patients, providers share the painful experience of death at the loss of their patients. The recurrent awareness of death is a threat to keeping their seated fear of death constantly at the surface and exposing them to continual helplessness and despair. Some of the participants recommended the

purposeful use of compassion from health providers as part of being patient, considering the fact that health providers see many patients each day.

However, it would be naïve to think that belief in sacrificial love constitutes a guaranty for practicing compassionate care, Kryst's suggestion supports Mamia and Massaga's (1999) advice to refer health concerns to God for help but also to do this as part of the process of loving others and being selfless.

Because belief in God, prayer and spiritual intervention are common to Native Cameroonian religious beliefs as well as to Christian beliefs, it seems reasonable to suggest that prayer to God can be used as a means for providers and patients to express love and support to other community members.

Narrative and Dialogue in Interaction

My fourth question sought answers about the narrative and dialogical quality of patient and provider interactions. My question RQ4 is: in what ways do the interactions between providers and patients incorporate narrative and dialogue? According to patients' and providers' stories, interactions with one another are molded by the quality of the communicative exchange. Charon (2009) connects this kind of communication with narrative when she says "Narrative medicine recognizes that the central events in health care are the giving and receiving of accounts of self" (p. 120). Charon's proposition was reiterated by Cameroonian patient and provider participants' stories when they noted how listening, time for the other and treatment as family were applied or desired during patient and provider communication.

Listening

When asked how they knew that their health providers cared about them, most patients answered that the providers cared when they took the time to listen. Some of the doctors like

Queen also emphasized the importance of listening to the patients in order to better care for them, Queen shared the fact that she starts each one of her visits saying: "je suis a votre ecoute" which is a formal way to say " I am all ears." The importance of listening during patient-provider encounters cannot be overstated. Charon's (2009) advice is similar to Queen's practice since Queen starts her visits by letting the patients know that she is interested in them as people first and then she examines their bodies. Responses from doctors and patients showed that listening is a self expectation of providers as well as an expectation from patients for providers.

Queen also noted that some of her patients would make comments about other doctors, complaining about the fact that these doctors were not able to listen to them so they stopped visiting them. Patient participants felt that health providers often were unable to properly understand their illness and care for them because they were not able to listen. This feeling is supported by Charon's (2009) work on narrative medicine when she recounts the story of her encounter with a patient during which her use of listening allowed her to connect the dots and serve as an agent of reconciliation between the patient and his ill body. Instead of prescribing an MRI, she prescribed an automatic wheel chair because she listened (Lipari, 2004) to the patient and understood his value for self-reliance. Lipari discusses this form of listening by describing it as the conscious suspension of categorical knowledge in order to understand the other. Coeur, one of the doctor participants, engaged in this form of listening while dealing with a patient who was facing a serious disappointment from a loving relationship, but the patient also appeared to suffer from AIDS. After listening to the patient's accounts of self, this doctor realized that the patient's loss of weight and pain resulted from a severe case of ulcers triggered by her emotional affair. Coeur was then able to provide his patient with the necessary treatment, attention and reassurance needed to resolve her physiological and psychological health conditions.

The use of listening occurs during patient-provider communication with the use of questions and answers. The patient-provider interviewing process requires provider's utilization of strategic questions that provoke insightful patient's accounts of self. Some doctor and patient participants pointed out that patients would not speak unless a question was asked by the provider. Therefore it is the responsibility of the provider to craft questions that would invite patients into a dialogical space where they can encounter and meet their providers at a level of quality similar to what theorists call an ethical encounter (Lipari, 2004, Buber, 1966). In order to listen to her patient's emotional disappointment, Coeur (doctor) had to ask questions that would initiate such accounts. His use of questions allowed him to create the mental and metaphysical room for his patients' answers, and as a result, his listening led to an effective patient health outcome based on his caring communication practices.

While listening was a self-expectation for doctors and an expectation of patients about their doctors, it is a practice that is not usually common in the traditional Cameroonian culture. When Rosny (1985) recounts stories from the Nganga witch doctors and from going to a seer, patients are expected to be the ones to listen. Therefore the patients' desire for more listening from doctors and even from Native healers is one way that they can give voice to their silenced need for expression and encourage providers to use appropriate questions and make adequate dialogical space for them to share their accounts and express their beliefs.

The use of listening is undoubtedly a powerful practice, not only for facilitating real patient-provider dialogue, but also for allowing the two parties to metaphysically acknowledge each other (Lipari, 2004). It is also an effective strategy for reaching an accurate and relevant diagnosis. Based on patient and provider participants' accounts, the application of dialogical

listening is both necessary and possible within the Cameroonian health care context. However, listening requires adequate time on the part of both the providers and patients.

Time for the Other (the Patient)

In addition to listening, making time for the other (the patient) is another condition that interviewees mentioned as evidence of providers' ethical approach to patient care. Fildev, one of the patient participants, explains what is meant by time for the other in the context of patient-provider interaction. He says:

> It has to do with the length of the exchange. In reality, the doctor should take his time with the patient. That means that he listens to you, he allows you to speak, he listens, you say all that you have to say.

Fildev's explanation of this concept of time for the other suggests that enough time during the encounter means that the patient has the time to say all that he or she needs to say. Bob, one of the doctors, noted that he gives the patients enough time to "exhaust" themselves, that is, to pour themselves out. This condition is mentioned by Charon (2009) as essential for the preparatory process of listening when she starts her visits by letting her patients know that she is ready to receive them as whole persons and not just as bodies.

Making time for the other also requires a form of retraction of self in order to receive and understand the meanings embedded in the other's (patients') account (Arnett, 2001). Arnett discusses the importance of reorienting conversations from the viewpoint of self to that of the viewpoint of the other so that the other (the patient) gets the opportunity to voice his or her opinion. The agency of the patient evolves when the provider give the patient enough time to be heard and understood; this is the result of giving the gift of one's own time to the other. So for doctors to make room for the patient's voice, they also need to make adequate time to deal with

their patients. This is an ideal that should be part of the patient-provider encounter but one that is often limited because of the availability of providers and the power differences that exist between providers and patients.

Besides listening skills, patient and provider participants also noted that time for the other was a necessary feature for building relationships between patients and providers. Lescien, one of the doctors, says that he makes time to build relationships with his patients by reassuring them and connecting with them at the beginning of the consultation:

> Well, me, I don't know but I really like when my patients have a relationship that is not…the doctor that is high up and the patient that is down below, no. I like when there is a connection. So before I even start the consultation, I try to reassure them, so that most patients are…I do not know…patient-friends.

Lescien explains that before starting the biomedical consultation, he makes time for the patient by reassuring them, making them comfortable, making time to create a connection with the patient. Lescien stories about some interactions suggested that, after the initial rapport building, he sustains the rapport by opening up to his patients and sharing some information about himself that connects with patients' human feelings and emotions (Zaner, 2009). In line with Zaner's suggestions, Lescien relationship building with his patients resulted in a mutually satisfying provision of care for both provider and patient. Lescien's example supports the fact that relationship building between provider and patients involves making time; however, the outcomes of this time investment towards others (patients and providers) can result in mutual perceptions about the ethical quality of care, which was the case between Lescien and his patients. Besides friendship, the process of offering time to patients results in other positive outcomes such as trust.

Information about trust emerged mostly from doctor participants' accounts. Arean, one of the doctor interviewees, shared a story where the time he made for one of his patient's mother was trust building. Dimatteo (2004) emphasizes the fact that trust building is dependent upon communication practice, and in this case Arean made time to establish trust before presenting bad news to his patients. The following excerpt provides context for discussion:

> I am telling you the story, the body was right on the operating table. We started telling the family member that the situation was getting worse but we will do everything in our power to save the child. Already there is a shock wave, you send a shock wave that is manageable [for the patient], you understand? And this lasted three hours, I mean from the moment when I started talking the child was already dead, you understand? It lasted three hours.

Arean used three hours to announce the death of an only child to her mother. As Arean later explained, this time prepared the mother for the news and ultimately gained her trust so that he could guide her in the process of mourning her child. It is important to note that in Cameroonian culture, death is such a traumatic event, and after it occurs survivors often engage in forms of dangerous behaviors. Thus, Arean's success in gaining the mother's trust was an appropriate and effective move to preserve the mother's health or even life (Zaner, 2009).

In light of the emotional and spiritual fear caused by death within African societies (Mbiti, 1991) like Cameroon, the use of time for the other is part of building trust and a component of expressing authentic love and communion with the patient (Mamia & Massaga, 1999; Kierkegaard, 1995). Health providers can increase their impact on patients' health by reaching not only the patients' physiological but also emotional health. Meanwhile, the

providers' moral health is likely to improve when they believe that they successfully fulfill their duty to care for fellow community members (Mbiti, 1991).

Treatment as Family (Mutual)

Patient interviewees such as Jolly shared accounts about their favorable impressions of patient-provider encounters in which the provider treated them as family members. Jolly stated:

> She took care of me as if I was her own daughter….Yes, she really treated me as if I was her own daughter….She would always give me counsel.

Jolly was touched by her provider's care because she was treated as family an outcome that experts on Cameroonian culture predict. For example, Mbiti (1991) describes the importance of the family relationship within the context of African traditional culture, specifically concerning children and their parents, Mbiti noted that "parents have a duty to look after children, protect them, educate them, discipline them, clothe them and bring them up to be well behaved and integrated" (p. 175). Thus, when describing her relationship with her provider as mother-child relationship, Jolly specifically emphasized the giving of counsel and the way that the provider sought to protect her from the harm of sexually transmitted diseases. Gran's account describing his provider's special care for him while he was battling a deadly disease also referred to effective provider interaction as occurring when a patient is treated in a similar way to how a person would treat a family member.

To treat someone as family is to look after them using special care and protecting them as if one had a vested interest in the person's well being. This form of treatment seemed to be an expectation of patients and a belief inhering in native culture about the role of providers, but it was not necessarily an expectation that providers had for themselves. In native culture, traditional healers, specifically medicine men, are often consulted for family issues, such as

when a child is misbehaving. In this case, the medicine men give counsel to the parent about the child (patient) as part of their consultations (Mbiti, 1991). By providing this kind of counsel, the medicine man demonstrates vested care by treating the patient as a family member. Accounts from patient participants suggested that health providers who treated patients as family members demonstrated responsibility towards their patients in a way that reinforced Cameroonian cultural beliefs related to appropriate communication and enactment of values.

Proper treatment as the other is a concern for theorists using a dialogic approach and also for me as I apply the concept to patient-provider encounters in Cameroon. Treatment of the other as family creates a sense of responsibility towards the patient that is supported by the cultural expectations of communal living and the duty to care for community members (Moemeka, 1996; Mbiti, 1991; Mamia & Massaga, 1999). Even though some health providers currently utilize this dialogic approach to patient-provider interactions in Cameroon, in order for the "treatment as family" approach to remain viable both parties have to treat each other as family as Coeur explains. Coeur cared for his patient free of charge, and as soon as the patient was able to pay back the doctor for her services she did so, and she also showed care towards Coeur by thanking him thoroughly. Again, the financial and infrastructural restraints of the Cameroonian health care system impede providers' attempts to care for patients with vested interests. According to some doctors, the desire to properly care is usually interrupted by lack of necessary health facilities so doctors often have to turn away suffering patients.

In order to protect providers' moral and emotional health, it is important for patients to also apply "the treatment as family" approach during and after consultations with their doctors. Mutual applications of this dialogic approach to patient-provider communication have the

potential to reduce power difference between providers and patients and to enhance the ethical quality of health interactions.

Viewpoints about the Ethics of Interaction

In response to my fifth research question, I gathered information about the ethical quality of patient-provider interactions. My specific question in RQ5 is: what are the differences between how providers and patients view the quality or ethical aspects of the health related interactions they have with each other? I found that viewpoints about the quality of patient and provider interaction relate to the ways in which providers and patient evaluate their health interactions. Accounts from patients and providers interviewees showed that patients and providers perceived the quality of their interactions differently. Nilsen and Elstad's (2009) research, describing the miscommunication occurring in the United States because of the providers' biomedical interviewing process and patients' pain-distorted reality, concludes that it is possible for patients and providers to have a different evaluations of the same encounter. Some of the main differences in the perceptions of the health encounter surfaced around the issues of waiting time and rule following.

Waiting Time

As mentioned earlier, because of the financial crisis and because of patients' limited finances, the interviewed participants admitted going to the doctor only after their illness had become acute. For example, Gran's illness had evolved so rapidly that his mother did not have the time to take him to the hospital before he entered a coma stage. At this stage of the illness any form of waiting is multiplied in the consciousness of the patient and the patient's family members because of the intense pain being suffered by the patient (Nilsen & Elstad, 2009) and the patients and their family's fear of death. So in encounters, such as the one where Gran's

mother was turned down by the first health provider, the mother's perception of this medical encounter was negative. She perceived the provider as uncaring for asking her to wait while her child was dying, a natural response in the mist of such a traumatic event. Even though I did not hear the provider's side of the story, it is reasonable to speculate that there were no more facilities available to care for Gran, and he hoped that the mother would find another health care facility. Because of the emotionally sensitive state of patients and family members threatened by the prospect of death, health providers should show compassion toward the family in order to communicate in a loving manner even though the constraints of the health care system often keep them from either providing this kind of compassionate care or the necessary physical care.

Waiting time was also a concern mentioned by patients, who sometimes accused doctors of practicing favoritism. Revers, one of the patients, explained his frustration with doctors who allowed patients out of turn to receive consultations at the expense of other patients who were in line. Revers was not the only patient who highlighted this practice; others like Jolly, Leba, Norman, Kloklo also called attention to this same issue. The patients explained that this behavior was probably motivated by some form of financial or social gain for the providers. Patients felt unfavored and cheated during these kinds of patient-provider encounters.

Causing patients to wait makes providers appear to be uncaring, and this results in patients claiming that health encounters are unfulfilling. This is important because Probst et al. (1997) claim that providers would rather engage in caring patient-provider encounters, but the demands of the workload and constraints of their health care setting are so taxing that these encounters often do not take place. During my interviews with providers, some of them discussed the issue of waiting time. One of the doctors anticipated my interviews with patients, stating that patients would probably complain for having to wait so long before consultation, but

this doctor did not make any further comments about this matter. However Ladia, another doctor, clearly explained that her supervisor recognized that the quality of consultations mattered more than the number of consultations that a provider could give per day. While this philosophy encourages longer and possibly more meaningful encounters, it also means longer waiting time for the numerous other patients.

The creation of forums where health providers can freely explicate the constraints of their health care environment in order to express their goodwill towards patients and to explain the need for better infrastructures is necessary in order to have more rewarding and trust building patient-provider encounters. These platforms can constitute discursive places where patients can voice their own frustrations and find possible explanations for their misgivings about health providers.

Rule Following

Besides waiting time, rule following was another area of difference between health providers' and patients' accounts. During their training health providers are exposed to a high amount of technical knowledge, but they also learn to function under structures and according to many rules (Branch, et al., 1991; Conrad, 1988). Therefore, both the presence of rules and their application are important for the provider's effectiveness. Research (Conrad, 1988, Probst et al. 1997) on providers' training also shows that during their training health providers are too stressed to see patients as allies. So, in the context of Cameroon, patients like Leba who fail to follow the rules suggested by health providers likely will be perceived as enemies and a threat to the necessary health care structure and system. Considering the cultural expectations placed on people in positions of power (Mbiti, 1991), those who challenge rules established by health

providers and the systems in which they work are perceived as disrespectful and in need of more humility.

In contrast Branch et al. (1991) explain that during providers' training, bedside manner and practices of humanistic medicine are secondary. Therefore during patient-provider encounters; providers may be unprepared to approach conflict in a compassionate and caring way, leaving patients like Leba outraged and vexed about the situation. In ways similar to Leba, other patients, Norman and Revers, stated that rules within the Cameroonian health care setting were neither clear nor consistent, and when patients failed to abide by the suggested rules the providers' attempts to correct patients were often rude and uncaring.

Again it is important to explain how the systemic structures influence patients' care and doctors' provisions of that care in the Cameroonian health care settings. In Leba's example, rules suddenly changed when the hospital ran out of thermometers, so the rules regarding consultation fees were changed accordingly. Such changes frustrate patients whose financial health is precarious, and they also create challenges for health providers who need to readjust their methods of care to address problems outside of their control. Better health infrastructures and planning could possibly facilitate the maintenance of consistent rules to the benefit of both providers and patients.

At the individual level (Oetzel, 2009) providers and patients can both use religious values as a resource to manage patient-provider encounters and address conflicts that arise during the process of waiting and rule following. Providers' expressions of compassion and love while encouraging patients to follow new rules, and a humble attitude from the patients while they are asked to wait or to comply with new regiments, are necessary for preventing conflicts that negatively affect both providers and patients.

CHAPTER 7:

CONCLUSIONS

The study's purpose is to explore participants' accounts about health to understand ways in which cultural factors such as religion inform patient-provider communication in the Cameroonian health care context. In this concluding chapter, I identify the key contributions, the limitations, and the directions for future research.

Contributions

The present study contributes to health communication scholarship in terms of connections between health beliefs and culture, intersections between Western and holistic health models, and practical applications. Specifically, my contributions are the following: (1) understanding health beliefs and practices from the point of view of Cameroonian providers and patients; (2) showing the relevance of previous studies in this area of Africa about the salience of Native and Christian beliefs to health communication; (3) demonstrating the complex components of providers' and patients' health beliefs and how they influence health care practices; (4) providing insight into Cameroonian providers' and patients' conceptualizations of the quality of communication; and (5) constructing a theory about narrative medicine as something that is already practiced by many providers and a model that is desired by many patients. This approach to narrative medicine emerged in part as a result of provider's and patients' ability to incorporate Native and Christian beliefs into their interactions on the one hand and on the other hand to recognize when these beliefs should have been incorporated but were excluded from the patient-provider interaction.

These unique contributions were possible through the use of in depth field interviews applying the use of dialogical ethics and storytelling in order to facilitate participants counting

and recounting of their experiences. The study not only highlights the relevance of ethnographic approaches that utilize participants' voices while addressing issues that are particular to specific cultural contexts, but it also illustrates the importance of allowing the research questions to drive the research method.

Understanding Health Beliefs and Practices

Interviews from doctors and patients provided unique insights pertaining to the Cameroonian patient-provider encounter. The findings revealed the use of the biomedical model as part of the multidimensional strategy that also included native culture's holistic approach. Contemporary Cameroonians' conceptualizations of health and illness showed the presence of five forms of health, including: physiological health, moral health, emotional health, spiritual health, and financial health. Acknowledgement of these contemporary forms of health and their relevance to the Cameroonian context might ultimately help international health organizations to design preventive campaigns that better cater to the local community members' understanding of health.

Relevance to African Religious Literature

Christian and Native religious beliefs played an influential role in understanding patients and providers' beliefs as well as their practice of humility, compassion and gratefulness. The practices of ethical listening, taking "time for the other" and practices of "treating the patient as family" during patient-provider dialogic interactions showed some of the propriety and opportunity for the practice of narrative medicine in Cameroon. Finally, patients and providers differ in their views about health encounters, specifically as it pertains to waiting time and following rules. These differences need to be resolved if effective and ethical dialogue is to become the norm in patient and providers encounters in Cameroon. One solution may be to

create forums for public dialogic in which providers and patients can acknowledge their religious values and explain how these values underlie their expectations for compassion and love in patient-provider interactions.

This previous chapter explored the implications of findings pertaining to medical and cultural assumptions, health and religious beliefs as well as communication practices of Cameroonian patient and providers. The practice of humility, gratefulness and compassion by health providers and patients using, love, was the theme of many of the stories that patients and providers shared with me during my field interviews in Cameroon.

The findings of this dissertation research are important because they evolve from a unique research context that provides insight into the health beliefs and patient-provider interactions of under-researched and culturally complex groups in Cameroon. I discovered that patients' and providers' beliefs and interactions are influenced by the Western medical model as well as by patients' and providers' Christian and Native beliefs. The contributions of this study are unique because they add new knowledge about contemporary conceptualizations of health, the relevance of religious beliefs to health and to the practice of narrative medicine, and the connections to existing research about health communication conducted in the U.S. that is nonetheless relevant to medical interactions in Sub-Saharan Africa. Additionally, the findings of my dissertation are innovative because they examine health communication practices and interactions in the context of Cameroon, a health context that has never been studied in this way before.

Insight into Patient-Provider Quality of Communication

This study provides new knowledge in the area of patient-provider communication within the context of Cameroon. While other studies report finding about medical research conducted in

Cameroon, my focus on patient-provider communication in this region of the world has never been the focus of research. Findings from my dissertation research pertaining to differences in patients' and providers' perception of the quality of health interactions provides insights for training medical students preparing to practice within the Cameroonian health care context. The study provides additions to the body of patient-provider communication in Sub-Saharan Africa because I explore the connections between pre-colonial and post-colonial health beliefs and their relevance to health interactions. Awareness of the conflict resulting from differences in patients' and providers' expectation during the provision of health can contribute to more effective health interventions.

Theory of Narrative Medicine as Relevant to Cultural Practices

My research also shows the relevance of narrative medicine as it is practiced in Africa's oral traditional context. Hopefully, my research will provide grounds for further research and additional theorizing about patient-provider encounters and religion in other understudied contexts around the world.

The use of dialogic interviewing, allowing interviews to "happen" while the interviewer suspends personal categorical knowledge, is an innovation for interviews and for interpretive research. This form of data gathering builds on the work in the United States by Charon (2009) and Zaner (2009) in its focus on listening and the vulnerability of patients in the process of their sharing of stories about health interactions and health care. While using this interviewing method I, as the researcher, remained open and willing to be vulnerable and shared part of myself with those I interviewed. In this way, participants and the researcher have the opportunity to connect and co-create new knowledge. Application of this form of data gathering is especially well suited to the conduct of research in communal cultures because it resonates with cultural values of

participants, including humility, listening and connectedness, which are common to African communities and other communal-oriented cultures.

Limitations

It is important to acknowledge some of the limitations of this study mainly: the participants' selection process, religious affiliations of the population, the secrecy in acknowledging traditional beliefs, the urban locale where I conducted interviews and the inability to cross check the data with participants.

While snowball sampling was fit for the study, the participants recommended by individual points of contact shared the same religious affiliations, providing the study with accounts of mainly patients professing to be Christians. Results from the study are insightful and critical in highlighting issues of importance during Cameroonian patient-provider interactions, but the study also suggests the need to investigate perceptions of patients who are official members of religious groups other than Christian.

The secrecy of traditional religious practice complicates research access to official members of traditional religious societies; however, future collection of accounts from overtly practicing traditional religious believers might provide an even more nuanced understanding of Cameroonian health beliefs. It is important to note that the locales for interview data collection were Yaoundé and Douala, two main cities in Cameroon, thus findings from the present project are mainly relevant to these contexts and the specific participants involved in the project.

The gathering of data for this study was conducted in Cameroon during the summer of 2010, and as a result, I had limited accessibility of research participants after I transcribed my data. This made it impossible for me to cross-check the data with the participants. The process of cross-checking is a measure typically used by researchers to give participants the opportunity to

review the report and interpretation of data, to make sure that the investigator's representations of their accounts are accurate. Although I was unable to provide cross-checks of my data, I did receive the permission of providers to gather data if I provided them with a final copy of my dissertation and I plan to provide a copy to all of my study participants is they want to read it. The reporting and interpretation of my research participants' accounts was carefully done to faithfully reproduce participants' thoughts, ideas and stories. In order to ensure understanding of the cultural context, I utilized notes from my observations as well as transcribed accounts interview participants who are still accessible after the time when I gathered the interview data.

Future Research

This dissertation represents doors of opportunity for further research and applications. (1) Findings from this research project can be compiled, organized and presented to patients and providers to enhance understanding of their health interactions and help bridge the gap between them. (2) Results from the study can be used to help design, medical schools' curriculum in order to better prepare future health providers for their interactions with Cameroonian patients. (3) Future research can seek to identify ways that providers and patients can deal with conflicts that arise in the Cameroonian context that this dissertation explains. (4) Applications of the present research include returning to Cameroon and bringing together providers and patients in religious settings and conducting focus groups that will increase knowledge of providers and patients about their expectations from each other. (5) Future studies can conduct research in different locations in Cameroon. Ultimately, the present insight in conceptualizations of health in Cameroon can be further researched and presented to health organizations such as WHO (World Health Organizations) to encourage culturally relevant and effective health interventions in Cameroon and similar health communities.

My research constitutes the beginning stages of a theorizing process focusing on patient-provider communication in Cameroon and with cultures with similar economies and beliefs. The use of a qualitative and interpretative method at the initial stages is critical in order to properly understand the complexities in meaning about health interactions and health care among under-researched cultural populations. The data gathering methods I used are relevant to the culture I studied and enabled me to understand the world through the eyes of Cameroonians and their experiences of patient-provider interactions. Ultimately, when sufficient understanding of this group of people is acquired by researchers, they then can utilize the information they have gathered about qualitative data to develop quantitative methods that can make generalizations about a broad population from the questionnaire data they generate and the statistical analysis of that data. Specifically, my future research may create survey measures based on provider and patient narrative that I could administer to a different population in Cameroon or some similar region of Africa. I would try to create measures for humility, gratefulness and compassion as well as establish measures for what constitutes a satisfactory health interaction in a culture like that of Cameroon. In the future, I might also create health campaigns based on my knowledge about Cameroonian patient-provider encounters and my theorizing about what constitutes ethical patient provider dialogue. My research demonstrates that Cameroonians need and want patient-provider encounters that are culturally appropriate and that take into account their physical, psychological, and spiritual needs. Hopefully this dissertation research will lead to many other studies of patient provider interactions in culturally complex contexts.

Final Thoughts

To return to the story that I started at the beginning of this dissertation, I have to admit that the loss of the lady who worked as a nanny for our family was a traumatic and a memorable

event. I can remember the despair on her facial expression, and I could feel the psychological tension that she experienced, lost between two worlds, Westernized medicine and traditional religious health practices. I remember her holding a baby infant in her arms, using natural remedies to protect him from the "enemies of health….that had attacked her belly." I had no words to explain what I saw on her face and my little seven-year-old mind could hardly understand why she would believe her traditional healer and not her doctor. I wished I could help somehow, but I lacked the understanding of the situation and my culture as well as the words to provide comfort. Now, more than 20 years have passed. After exploring this memory for many years and praying for insight about why these events took place, at least now I have a better understanding for Miria's trauma. Maybe all I could give at the time was compassion through my love for her, but now I have an explanation of what Cameroonians believe, how their Native and Christian beliefs affect their views of medical providers, and how patients deal with illness and death that I lacked prior to the time I completed my dissertation research.

APPENDIX A: INSTITUTIONAL REVIEW BOARD PROTOCOL

INFORMED CONSENT READ TO PATIENT AND DOCTOR PARTICIPANTS

You are being asked to be part of a research project being done by Eudaline Patricia Hell, who is the main person responsible for the project and Dr. Jan Schuetz from the department of Communication and Journalism at the University of New Mexico. In this project the investigator examines what Cameroonians' think about meetings between doctors and patients. Other projects have shown that traditionally in Sub-Saharan Africa, people used to think of health in relations to a person's body, soul, community, and the person's connection to spirits. Other investigations show that traditional African cultures like the one in Cameroon change all the time. People change cultural beliefs depending on their new needs. Since needs in terms of community and money have changed since the times of colonization, in this project Eudaline Patricia Hell tries to understand what are the new beliefs that Cameroonians have concerning the meeting between doctor and patients.

You are being asked to be part of this project for two reasons. First, you are Cameroonian and you have leaved in Cameroon for more than 20 years. Secondly you will be involved in this project because you have met with a doctor or patients in Cameroon. The project will involve 30 Cameroonian subjects.

This form will explain the project, and will also explain the risks and benefits to you. It might be a good idea to talk about participating in this project with a close family member. If you have any questions, please ask Eudaline Patricia Hell.

If you decide to be part of this project, you will need to contact Eudaline Patricia Hell using the information at the end of this document. During your conversation with Eudaline Patricia Hell, please let her know the time and the place where you would like to have an interview with her. During the interview, you will tell her about some of your meetings with doctors/patients. Eudaline Patricia Hell will tell no one about your interview with her.

The interview will take about 30 to 40 minutes of your time. The only risks in being part of this study might be sharing information with someone that you hardly know, but know that the information shared will be kept confidential. There will be no direct rewards for being part of this project. However, information from this project might help better the meetings between providers and patients. If you do not want to be part of the project, nothing will happen to you because even if you decide to participate, your participation will stay confidential. If you decide

to be part of the project, the project team will protect your participation and the personal information you share, but the team cannot guarantee the protection of all the information that is directly connected to the project. Information collected as part of the project will be identified with a name different than yours. The information will be entered into a computer, and it will be locked in a secured place. Eudaline Patricia Hell will be the one to have access to your study information. The data will be kept for five years and then destroyed. There are no costs for taking part in this project, but Eudaline Patricia Hell will be responsible for other costs related to your care.

You will be informed if any important findings that become available during the project, for example changes in risks or benefits related to your participation in the project or new possibilities to take part in the study.

You are free to participate or not participate in this study. You can decide to stop your participation in this project at any time. If you decide to not participate, you need to simply cancel your appointment with Eudaline Patricia Hell or stop the interviewing process.

If you have any questions, concerns or complaints at any time about the project, Eudaline, doctoral candidate at the University of New Mexico will be happy to answer them at 22 31 95 63 (Cameroon) or (001) 870- 273- 6794 (United States) from 8am to 7pm. If you would like to speak with someone other than Eudaline Patricia Hell in cases of concerns with the project, you can call the group responsible for research at University of New Mexico (UNM Institutional Review Board) at (001) 505-272-1129. The Institutional Review Board from the University of New Mexico is a group of people from the University of New Mexico who are not connected to specific research projects but make sure that people who participate in research projects are well protected.

You are making a decision to participate in this project. Your signature below means that you read the information provided (or the information was read to you). Even though you signed this document you still have all of your legal rights as a participant in this project.

I have had an opportunity to ask questions and all questions have been answered to my satisfaction. By signing this document, I agree to be part of this project. A copy of this document will be provided to you.

_____	_____	_____
Name of Adult Subject (print)	Signature of Adult Subject	Date

I have explained the research to the subject or his/her legal representative and answered all of his/her questions. I believe that he/she understands the information described in this document and freely agrees to participate.

_____

Name of Investigator

_____	_____
(Signature of Investigator/Research Team Member)	Date

APPENDIX B: PATIENTS INTERVIEW PROTOCOL

- RQ1: How do patients/providers understand their communication with each other?

Health Beliefs

- RQ1a: What kinds of health beliefs are reflected in their narratives?
    1. Please finish the following statements (use a story to illustrate how this specific activity, idea, state of being or thing makes you healthy)
        - I feel healthy when…
        - My doctor says I am healthy when…
    2. When do you consider yourself ill?
    3. When you were a child, what did your family do when you were ill?

Provider Patient Interactions

- RQ1b: What cultural values do they emphasize during interactions between patients/provider?
    4. Think about your best doctor. Now can you tell me why he or she is your best doctor?
    5. Would you share a story of your most memorable encounter with him or her? What did he say and do that made him memorable?
    6. Think about the same doctor, and try to put yourself in his place. Can you tell me the story of the same encounter from his or her perspective?
    7. Would you say that you are this doctor's best patient? Why?
    8. When does a doctor behave in a culturally inappropriate way? Can you recall and tell a story of an encounter with a doctor who behaved really inappropriately?

Religious Values in Traditions

- RQ2: How are Christianity and Native Religions reflected in the narratives about communication between provider and patients?
    9. Do you belong to a religious group? If so, what would your religious leader say about the way your favorite doctor treats you? If you do not belong to a religious group what would your traditional leader say about the way your favorite doctor treats you?
    10. What link do you see between your health and your religious beliefs?

11. Do you ever go to your religious leader or traditional leader in case of illness? Would you tell me a story about such a visit?
12. Do Christian practices or Native religious practices manifest in your interaction with your doctor? How do these practices or communications manifest?

Communication Practices

- RQ3: What do patients and providers say about the nature of their communication?
    13. During your consultation, how do you share information about your illness with your doctor? Do you simply answer his questions? Or do you take initiatives?
    14. Do you ever use stories to tell your doctor about your state of health? Why?
    15. How does your doctor tell you about your illness?
    16. How can you tell that a doctor cares about you? Can you think about a story to illustrate your point?
    17. How do you know that he is listening to you during the consultation?

APPENDIX C: DOCTORS INTERVIEW PROTOCOL

- RQ1: How do patients/providers understand their communication with each other?

Health Beliefs

- RQ1a: What kinds of health beliefs are reflected in their narratives?
    1. Please finish the following statements (use a story to illustrate how this specific activity, idea, state of being or thing makes you healthy)
        - I feel healthy when…
        - My patient is healthy when…
    2. When do you consider someone ill?
    3. When you were a child, what did your family do when you were ill?

Provider Patient Interactions

- RQ1b: What cultural values do they emphasize during interactions between patients/provider?
    4. Think about one of your best patients. Now can you tell me why he or she is your best patient?
    5. Would you share a story of your most memorable encounter with him or her? What did he say and do that made him memorable?
    6. Think about the same patient, and try to put yourself in his place. Can you tell me the story of the same encounter from his or her perspective?
    7. Would you say that you are this patient's best doctor? Why?
    8. When does a patient behave in a culturally inappropriate way? Can you recall and tell a story of an encounter with a patient who behaved really inappropriately?

Religious Values in Traditions

- RQ2: How are Christianity and Native Religions reflected in the narratives about communication between provider and patients?
    9. Do you belong to a religious group? If so, what would your religious leader say about the way you treat your patients? If you do not belong to a religious group what would your traditional leader say about the way you treat your patients?

10. What link do you see between your provision of health care and your religious beliefs?
11. Would it be advisable to go to a religious leader or traditional leader in case of illness? Would you tell a story illustrating such a visit?
12. Do Christian practices or Native religious practices manifest in your interaction with your patients? How do these practices or communications manifest?

Communication Practices

- RQ3: What do patients and providers say about the nature of their communication?
    18. During your consultation, how do you share information about the diagnosed illness with your patients? Do patients get an opportunity to ask questions and express additional concerns? Do they use the opportunity or simply answer questions?
    19. Do you ever use stories to tell your patients about their state of health? Why?
    20. How do your patients tell you about their illness?
    21. Can patients tell that you care about them? Can you think about a story to illustrate your point?
    22. Who does the most listening during the conversation with your patients? What are some measures that you take to listen to the patients? How would you describe the process?
    23. How do you know that your patients understand you during the consultations?

APPENDIX D: PARTICIPANTS PROFILES CHART

Patients Pseudo Names	Descriptions
Kryst	- Single Cameroonian man living in a big city, experienced small towns, university student, with difficult health history, identified primarily as Christian in the Presbyterian church
Revers	- Cameroonian man living in big city, working head of a family, experienced few but challenging health problems, identified as born again Christian
Norman	- Single Cameroonian man living in big city, university student, had a parent in health care, identified as believing in God and follower of the Bible.
Kloklo	- Single Cameroonian young woman, student in big city, highly involved in Christian organizations, identified as believing in Jesus.
Gran	- Single Cameroonian man, student in big city, experienced few but intense health problems, desires to be in health care, identified as protestant
Leba	- Single Cameroonian man, university student in big city, with influential family members in health care, identified as protestant and member of the Presbyterian church and keeps it private
Antonia	- Single Cameroonian young woman, lives in big city but has experienced life in small towns, identified as a member the Presbyterian church
Jolly	- Single Cameroonian young woman, living in big city, identified as protestant believing in God the Father, the Son and the Holy Spirit.

Fildev	- Cameroonian man, single, university student, living in big city, has a parent in church leadership, identified as Christian from Presbyterian church
Kam	- Cameroonian man, living in big city, emphasized his identity as follower of Christ and not religious membership
Sicka	- Cameroonian woman, married, working, living in big city, identified as Christ centered believer
Emil	- Cameroonian man, single, working, living in big city but lived in small towns, identified as Christian
Doctors Pseudo Names	Descriptions
Rey	- Has lived in Cameroon over 10 years, practices medicine in a public hospital and lives in big city, has experienced small towns and other countries, identified as believing in God
Queen	- Has lived in Cameroon over ten years, practices medicine and lives in big city, identified as Christian but not belonging to any religious group
Lescien	- Practices medicine in private health facility in a big city, has lived in Cameroon over 10 years, married, studied abroad, identifies as non religious
Ledis	- Young doctor, has lived in Cameroon over 10 years practices medicine in a public health facility in a big city
Coeur	- Young doctor, has lived in Cameroon over 10 years, early exposure to medical profession, practices in public health facility, identified as Pentecostal but keeps beliefs private while at work.
Bob	- Has lived in Cameroon over 10 years, practices in a public hospital in the city, has experienced life in rural settings, identifies as a believer in Christ.
Arean	- Identified as an explorer of religious beliefs, has lived in Cameroon over 10 years, practices in a public health care

	facility in city area.
Ami	- Young doctor, single, has lived in Cameroon over 10 years, practices medicine in public hospital in the city, has experienced life in smaller towns.
Ladia	- Has lived in Cameroon over 10 years but has experienced life in other countries, early exposure to medical profession, practices in a public hospital in the city, identified as Catholic.
Sam	- Married woman, practices medicine in a private health care facility in a big city, identified as born again Christian

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