Jurnal Komunikasi Indonesia

Volume 10
Number 1 *March*

Article 1

3-1-2021

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Volume X
Issue 1
March 2021
ISSN 2301-9816

JURNAL
KOMUNIKASI
INDONESIA

Health Communication in Mitigating The Risk of Physician and Controlling Covid-19 Outbreaks: A Qualitative Study on Emergency Department's General Practitioners

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Abstrak/*Abstract*

As the front line of detection of patients infected with Covid-19, doctors have a high risk of transmission. However, doctors' ability to provide proper communication with a unique medical interview process and persuasion of health context is needed. Patients can be open and honest about the illness symptoms and get the required information as prevention. This study aimed to determine doctor-patient communication changes and how information can reduce doctors' risks of infection. Then, this research also aimed to know how the information from health communication to patients and their families can increase awareness toward the outbreak, change patients' behavior, and likewise build a resilient society. As a qualitative case study, through semi-structured interviews with fourteen general practitioners of the Emergency Department and fourteen patients, we constructed some barriers and opportunities when doctors gave patients information about Covid-19 and figured out how it could be influence behavior. The attitudes and communication behaviors of doctors underwent several modifications, namely changes in the premedical examination, anamnesis, providing information, verification of information, and a tendency to change the relationship from mutualistic to paternalistic-informative. Provision of knowledge through information was carried out in a balanced way between risk and prevention so that patients behaved according to medical advice. Changes in community behavior indicated a difference in the community's lifestyle, although it has not yet been consistent, to become a resilient, adaptive, and preventive community against pandemics. This paper provided findings for health communication value and offered useful suggestions for general practitioners, especially by educating vulnerable people during catastrophic events such as Covid-19.

Sebagai garda terdepan pendeteksian pasien yang terinfeksi Covid-19, dokter memiliki risiko penularan yang tinggi. Namun, diperlukan kemampuan dokter untuk memberikan komunikasi yang tepat dengan proses wawancara medis yang unik dan persuasi dalam konteks kesehatan. Sehingga pasien dapat terbuka dan jujur tentang gejala penyakit dan mendapatkan informasi yang diperlukan sebagai pencegahan. Penelitian ini bertujuan untuk mengetahui perubahan komunikasi dokter-pasien dan bagaimana informasi dapat mengurangi risiko dokter terinfeksi. Selanjutnya, dengan menyampaikan komunikasi kesehatan kepada pasien dan keluarganya bagaimana informasi tersebut dapat meningkatkan kesadaran akan wabah, mengubah perilaku pasien, bahkan membangun masyarakat yang tangguh. Sebagai sebuah studi kasus kualitatif, melalui wawancara semi-terstruktur dengan empat belas dokter umum di Instalasi Gawat Darurat dan empat belas pasien, kami membangun beberapa hambatan dan peluang ketika dokter memberikan informasi kepada pasien terkait Covid-19 dan mencari tahu bagaimana hal itu dapat memengaruhi perilaku. Sikap dan perilaku komunikasi dokter mengalami beberapa modifikasi, yaitu perubahan pemeriksaan pramedis, anamnesis, pemberian informasi, pembuktian informasi, dan kecenderungan untuk merubah hubungan dari mutualistik menjadi paternalistik-informatif. Pemberian pengetahuan melalui informasi dilakukan secara seimbang antara risiko dan pencegahan agar pasien berperilaku sesuai anjuran medis. Perubahan perilaku masyarakat yang terjadi menunjukkan adanya perbedaan gaya hidup masyarakat, meskipun belum konsisten, menjadi masyarakat yang lebih tangguh, adaptif, dan preventif terhadap pandemi. Penelitian ini memberikan temuan untuk nilai komunikasi kesehatan dan menawarkan saran yang berguna bagi dokter umum, terutama dengan memberikan edukasi kepada orang yang rentan selama peristiwa pandemi seperti Covid-19.

Kata kunci/*Keywords:*

health communication, doctor-patient, risk mitigation, behavior change, Covid-19.

komunikasi kesehatan, dokter-pasien, mitigasi risiko, perubahan perilaku, Covid-19.

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Introduction

The Covid-19 pandemic has been recognized as an urgent and serious global public health crisis. Data from the Indonesia Ministry of Health dated August 21, 2020, mentioned that the number of Covid-19 cases in Indonesia reached 149,408 cases and spread across 34 provinces. With a death rate of 4.4%, which is above the world average of 3.5%, Indonesia has become one of the countries with the highest positive cases

and mortality rate in Southeast Asia (Ministry of Health, 2020).

The "super spreader" findings in China, where one positive Covid-19 patient infected ten medical personnel and four other patients, highlighted that the virus can spread quickly (Wang et al., 2020). This case proves that medical personnel's solemn duty will continue at least until a vaccine is found. Article 3 of the 2018 Health Quarantine Law regulates public and health workers' protection and legal certainty during a pandemic. The safety risks of health workers must be a common concern for both the community and the government.

The Indonesian Doctors Association (IDI) reported that, as of 21st August 2020, 86 doctors in Indonesia died from Covid-19, in which general practitioners formed 54.7% of the total mortality rate. Achmad Yurianto, a spokesperson of the Covid-19 Rapid Response Task Force, said that data in Indonesia showed that about 70% of Indonesians who were infected with Covid-19 did not show common symptoms. This makes identification during medical consultation become more challenging in order to make a diagnosis, especially if the patient is not honest. Under a pandemic, health workers are at risk of infection (Liu et al., 2020). Furthermore, general practitioners (GPs) play an important role in providing whole-person and patient-centered care during this crisis (Stone, 2020).

The hospital emergency room is the entrance to health services with high service intensity to have a high potential for incidents (Harjayanti et al., 2014). Every day doctors meet with patients and interact with many people. For most patients, visiting the emergency room means immersing in a different culture. How they work, many emergency staff and their reciprocity, and the questioning and unfamiliar environment can easily lead to patient's anxiety, confusion, loss of control, frustration, and long and unexplained waiting times (Olthuis et al., 2014; using the constant comparative methods (ie, starting the analysis with the collection of dataO'Gara & Fairhurst, 2004). The profession as a doctor requires communicating with patients during the medical consultation process, which is the most critical component in making a diagnosis and treatment, and this process requires a good and competent interpersonal communication approach (Menawati & Kurniawan, 2015).

Several studies have mentioned several factors which underlie doctor and patient communication effectiveness during medical consultations, including empathy by doctors, efficient information conveyed, accommodated interpersonal relationships, exchange information process, and medical decision-making (Boediardja, 2011; Haskard et al., 2009). However, in line with the increase in the number of infected people, the heavier and more burdensome it is for GPs to assess, detect, and treat suspected cases.

As a prevention effort, the community must become the first defense line fighting this infectious disease. In practice, Covid-19 positive patients with no symptoms to low risk can be managed in the community by remote assessment by doctors through self-isolation (Greenhalgh et al., 2020). Each country will adopt different policies regarding (mostly asymptomatic) patient management strategies in the community according to local conditions, facility availability, etc. Based on data and field facts, it still shows positive patients with comorbidity and the elderly have a high risk of death (Wu & McGoogan, 2020).

Healthcare professionals should cooperate with the mass media and help identify inaccuracies. Misleading headlines anger public members, cause fear, interfere with public communication, and reduce outbreak prevention measures (Raghuvir et al., 2020). Furthermore, information about the coronavirus must be informed to the individual and community. The communication process to increase emotional responses and change behavior in dangerous situations is useful when using empathy in providing this information (Sandman & Lanard, 2003). Meanwhile, Maloney et al. (2011) stated that to persuade people to act and behave according to health directions, in the message, it is necessary to have information that makes people aware of threats and also increases self-awareness to take the required action (Maloney et al., 2011). It can be the hope of reducing the threat posed. It is exciting to know the limitations of information and how the doctor delivers the health context to patients and their families.

When new types of diseases are spreading, especially in the initial phase and even several months afterward, epidemiological data collection is ongoing, so there is a lack of comprehensive scientific evidence (Rubinelli et al., 2020). This health emergency provides quick lessons for building more resilient societies. Doctors have a strategic role in health promotion by increas-

Table 1. Doctor Death Data

Number of Death	March:11 ; April:14 ; May:4 ; June:10 ; July:30 ; August:17		
Profile	**Age**	**Number of Death**	**Percentage**
	<50	35	40.7 %
	>50	51	59.3 %
	Age	**Number of Death**	**Percentage**
	Medical Specialist	39	45.3 %
	General Practitioners	47	54.7 %

Source: Kamil et al., 2020

ing health control to improve health, especially when examining patients. Health facilities as gatekeepers also play a strategic role in promotional programs and prevention. Both of these conditions give doctors a role which is highly strategic in running its promotion and prevention programs (Ashcroft, 2015; Pace et al., 2014). This study aimed to determine and explore how doctor-patient communication changed, how the Covid-19 information was delivered to patients, and the purpose of health communication to increase awareness of the outbreak could create a mitigate way and build a resilient society.

Literature Review

Interpersonal doctor-patient communication as part of health communication

A doctor must be able to communicate effectively with patients following the Indonesian Doctor Competency Standards (SKDI). Patient trust can be built through conversation during this process of extracting and exchanging information. Interpersonal communication skills help doctors to get information from patients by diagnosing the patient's disease correctly and adequately in order to provide medicine or the right steps for the patients (Nugroho, 2009). Research conducted by Ha & Longnecker (2010), showed that most complaints about doctors are related to communication competence problems, not clinical competence (Ha & Longnecker, 2010). On the other hand, some literatures found a positive correlation for a good communication between doctors and patients, which can better regulate emotions, increase understanding of medical information and perception of information, increase expectations, and build full relationships with doctors. Therefore, the patients trust and obey his medical advice and directions (Firdous & Hiba, 2019; Markides, 2011; Ong et al., 1995).

The relationship between the doctor's interpersonal ability and the patient's recovery is obtained by forming excellent and friendly relationships with patients and assuring them that they will soon be better. This is more effective than health practitioners who continually give impersonal (unfamiliar and unfriendly), formal or uncertain consultations. The result is that health communication has a positive impact, i.e. a significant determinant of patient satisfaction and adherence to medication and care. Explicit forms of health communication are carried out through interpersonal contact, such as doctor's friendliness, polite behavior, social conversation, encouraging and empathic behavior, building partnerships, and empathy expressions during communication (Arianto, 2013).

During medical consultation, doctor-patient communication has some goals, such as building relationship, assessing and understanding patient's problems, and collaborating for management (Cole & Bird, 2014). Typically, medical consultations have a standardized protocol in which physicians explore the patient's needs on the subjective and objective level and use their knowledge, skills, sensitivity, intuition, and conscience to make diagnoses and plan solutions to reduce health problems.

In a study conducted by Cegala et al. (1998), they observed changes in communication during the medical consultation process using information exchange with factors of provision, search, and verification of information and relational development and socio-economic communication factors. So far, these factors have the standard protocol in assessing the medical consultation (Cegala et al., 1998). Although this protocol has not always been followed in practice, it has become the axis of standardization, generalization, and simplification of consulting objectives: health care against diseases (Torres et al., 2018). Then, during a pandemic, how can this process be used to reduce the risk of doctors becoming infected? How can we include the health communication campaign related to Covid-19?

Moreover, as a model of interpersonal communication between a doctor and patients and part of educating and motivating patients in the health context, the ideal relationship between doctor and patient is mutualistic, where the doctor will direct treatment and make decisions about it and decisions about patient treatment have been approved in advance by the patient (Tongue et al., 2005). Mutualism means mutual respect and cooperation. It resolves a two-sided knowledge asymmetry between the patient-doctor and is related to optimizing processes, plans, and outcomes (Black & Gallan, 2015).

Other results of a study outlining four models of the physician-patient interaction consist of emphasizing the different understandings on the goals of the physician-patient business, physician's obligations, role of patient values, and conception of patient autonomy (Emanuel & Emanuel, 1992), which were then adapted by Roter & McNeilis (2003) and also Black and Gallan (2015). The model communication categorization will direct the different status approaches, processes, and emotional interactions between them. Successful communication between doctors and patients will generally lead to comfort and satisfaction for both parties (Kurtz et al., 2005).

This study is not less important, trying to provide an overview of the limits of information that the community should receive from the medical side. Witte described how people manage the fear which results from messages about "threats." One of the motivators used in messages during communication campaigns to prevent antisocial and unhealthy behavior is fear (Witte, 1992; Witte & Allen, 2000). Witte's theoretical model explained that people have three responses to messages based on fear. Two main factors explain how people will generate fear, perceived threat and perceived efficacy (Littlejohn et al., 2017).

The combination of the perceived threat and three perceived efficacy of the three responses - no response, fear control, or danger control -

Table 2. Four Model Physician-Patient Relationship

Item	Informative	Interpretative	Deliberative	Paternalistic
Patient Values	Defined, fixed, and known to the patient	Inchoate and conflicting, requiring elucidation	Open to development and revision through moral discussion	Objective and shared by physician and patient
Physician's Obligation	Providing relevant factual information and implementing patient's selected intervention	Elucidating and interpreting relevant patient values as well as informing the patient and implementing the patient's selected intervention	Articulating and persuading the patient of the most admirable values as well as informing the patient and implementing the patient's selected intervention	Promoting the patient's wellbeing independent of the patient's current preferences
The conception of a patient's autonomy	Choice of, and control over, medical care	Self-understanding relevant to medical care	Moral self-development relevant to medical care	Assenting to objective values
The conception of a physician's role	Competent technical expert	Counselor or adviser	Friend or teacher	Guardian

Source: Emanuel & Emanuel (1992)

shapes how people deal with the situation. When someone has a low perceived threat, there is no response to the message. When a person sees a threat, he is motivated to take action. The greater the perceived risk and the more vulnerable a person is to the danger, the more likely they will want to act to avoid negative feelings associated with fear. Perceived efficacy determines whether the response takes the form of anxiety or control of danger. People who feel they can do something about threats tend to use hazard control (Littlejohn et al., 2017).

Health communication to develop behavior change and build a resilient society

When we are discussing health communication, there are some context related to the health sector, e.g. the relationship between doctor-patient, individuals' capability in accessing and utilizing health information, individual adherence to the treatment process that must be undertaken and adherence to medical advice received, delivery of health messages and health campaigns to disseminate information about health risks to individuals and populations, an overview of health profiles in mass media and culture, education for health service users on how to access public health facilities as well as health systems and development of program applications such as telehealth (Rahmadiana, 2012).

Knowledge in this field can be categorized based on its emphasis on two major groups: perspectives based on the communication process and perspectives based on messages in current and expected communication. The communication process-based approach explores how health meanings are expressed, interpreted, and exchanged, i.e. a method of investigating the interaction and symbolic structuring associated with health. In contrast, the message-based perspective of communication focuses on the formation of useful health messages and strategic efforts to create effective communication which can achieve the health sector stakeholders' goals (Zoller & Dutta, 2008).

Nowadays, research on health communication is widespread, and a lot of researches and theoretical studies have been carried out in this area. Information is studied from two main perspectives. First, the information describes the nature of health and disease. In other words, we understand what it means to be healthy or sick through the stories we tell. Second, use messages to encourage individuals to make healthy behavioral choices. The information in the health communication campaign tries to change attitudes and behavior by addressing various personal, psychological, and social factors in people's lives.

To have a big picture of Covid-19 impact on society, we used a transtheoretical model of change by Prochaska and DiClemente, which is also known as the stages of change model (Prochaska & DiClemente, 1983; Zimmerman et al., 2000). With this model, we can detail how the

message from a medical perspective can change or move society. Stages of changes and processes of change are two major constructs of this model. Miller and Rollnick began using a patient-appropriate interaction format based on change stages and it may be most useful in the early stages of change when motivation is critical. He argued that medical interviews are the most important element in promoting motivation for change and relying on a specific approach in order to achieve change in life's problems, which are beyond the specifically targeted changes. Furthermore, a definite concept for motivation is the expression of empathy, developing discrepancy, and participating in rejection or resistance (Miller & Rollnick, 2002).

Research Methodology

This study used a case study qualitative research method, which was intended to understand and focus of the study was a contemporary (as opposed to entirely historical) phenomenon, i.e. a "case" - which is being experienced by the research subjects, whether in terms of attitude, behavior, motivation, and action to get a comprehensive and in-depth picture from the perspective of the study participants (Yin & Campbell, 2018 Santoso & Royanto, 2009). As this is a single case study, we used a semi-structured interview as the primary data source. Secondary data were collected from related literature, books, analyses of any information in the media (print, electronic and online), non-participatory observations, laws and regulations which are mostly related with Covid-19, and other data support linked to the theoretical foundation of communication (especially interpersonal and health).

Data collection techniques were semi-structured interviews as this is a descriptive qualitative study and must meet the conformity requirements (appropriateness). We entirely determined the selection of informants in qualitative research, which Patton (2015) called as purposeful sampling, namely selecting informative cases (information-rich cases) based on the strategies and objectives pre-determined by researchers, and the number of which depends on the objectives and resources of the study (Patton, 2015).

After selecting the criteria, i.e. serving in the ED/Outpatient Clinic, holding a license to practice, joining IDI, and being on duty during the beginning of Covid-19 (range: March to June 2020), we chose 14 doctors. Qualitative research tends to be open in its design and methods so that the method for collecting data from the subject can be changed and adapted to the context and setting when the research is taking place. Thus, in this study, the number of respondents was not decided initially, but it was based on data saturation. Saturation is the principle in collecting data from respondents where information is collected until it reaches a saturation point; that is when no new information is obtained (Poerwandari, 2013).

Working Hospital: H1 (First Line Hospital Handling Covid-19); H2 (Second Line Hospital Handling Covid-19); H3 (Third Line Hospital Handling Covid-19) and HO (Other Hospital/Clinic/Public Health Center)

To obtain the validity of the patient-centered approach data under the criteria of having examinations on both individuals or families in the emergency room during the pandemic or getting explanatory information about Covid-19 from a doctor, 14 patients were chosen. Online interviews were conducted from June to August by asking the same questions regarding experiences, changes, and limitations of information on Covid-19 to obtain information according to specific purposes.

Table 3. Data Informant: Doctor

Data	D.1	D2	D.3	D.4	D.5	D.6	D.7	D.8	D.9	D.10	D.11	D.12	D.13	D.14
Initial	DPP	SDF	INF	DP	RA	ASN	EHP	BPS	NU	AK	MMD	NW	SR	FC
Sex	F	F	F	F	M	M	F	F	F	F	F	M	M	F
Age	28	36	29	38	29	28	28	27	28	28	29	29	26	29
Hosp.	HO	HO	HO	HO	HO	H2	H3	HO	HO	HO	HO	HO	H3	H1

Table 4. Data Informant: Patient

Data	P.1	P2	P.3	P.4	P.5	P.6	P.7	P.8	P.9	P.10	P.11	P.12	P.13	P.14
Initial	SW	SAU	HI	LJ	RIH	RI	WM	ARR	FT	MHU	RA	OPN	NR	EP
Sex	F	M	M	F	F	F	F	M	M	F	F	F	F	M
Age	29	28	30	30	24	29	28	26	31	29	27	35	30	28
Occup.	O2	O2	O5	O3	O5	O5	O1	O1	O4	O3	O2	O5	O5	O3

Occupation: O1 (Civil Servant/Police/Military); O2 (BUMN); O3 (General Employees); O4 (Entrepreneur/Independent Business); O5 (Others)

Data analysis technique used was the Miles, Huberman, and Saldaña approach, namely data condensation, data display, and conclusions verification (Miles et al., 2014). Lastly, we used the data triangulation as our data validation technique in which we applied source, data, and researcher triangulation.

Results

For the reason of prevention, participants said that there was a massive change before they began their shift. They always wore PPE as an outer layer and added an N95 mask, google glasses, etc. as pre-medical examination.

PPE (Personal Protective Equipment) is much more complete to minimize the transmission risk. Wash hands before and after examining the patient. The patient's seat during history taking is spaced apart. Patients who do not wear a mask are prohibited from entering the service center. There is a policy where screenings for newcomers and travelers are carried out in different rooms. Rooms are disinfected before and after practice hours. The PPE stock are increased. Health promotion is conducted by providing regular education to the village. Leaflets and banners about Covid-19 are put in the registration and waiting room. – D

With the use of PPE by medical personnel during examinations and health consultations, participants did not feel significant obstacles. The entire medical consultation process has not changed much. It followed all operational standards, such as diagnosis, causes, and treatment of health problems. They also explained each required test's purpose, took the prescribed medication, and how the prescribed medication would help in overcoming the problem, and possible side effects of medicine were also described by the doctor. The slightest problem derived from patients' struggle to hear the GP's voices due to masks worn by the GP.

Because, the hospital's procedure indeed requires that a rapid test is mandatory before the examination is provided. What if the condition of an emergency patient requires fast medical action? Just a little confused about it. – P

A little difficult to hear the detailed explanation due to the use of PPE. – P

Communication during medical interviews has also changed. The most significant cue is when the patient was found to have high value in his screening results leading to Covid-19. Thus, further explanation was needed. As a new outbreak, additional time is required to convey this and educate patients about the symptoms, causes, and how to treat them.

After it is confirmed as covid, a series of medical consultations is still carried out. But, if there is a contact history with a Covid-19 patient, work and travel history will be advised for additional examinations in the form of rapid test or PCR test. – D

Be more observant in digging up complaints, residential address, work history, travel history, have there been any contacts with positive patients with Covid-19, have they visited crowded places. All socioeconomic and cultural aspects were explored. – D

Also, there is a more comprehensive differential diagnosis, which sees symptoms not only from the disease, but also other possibilities related to Covid-19. In addition, several simple supporting examinations are prescribed, namely laboratory exams (complete blood), for the initial screening of possible Covid. – D

Make the patient's atmosphere comfortable and safe so that patients are willing to be honest about their condition, and we add a stamped agreement sheet for inpatients who don't lie about things related to Covid-19. – D

The pandemic has made people, especially those who later experience health problems and have to go to a health center or hospital, become anxious. This also underlies the opinion differences in several participants. Effective communication about the virus is sufficient, mainly how to prevent it, when symptoms are found, and what kind of treatment. However, some participants thought that a medical consultation shall provide comprehensive and elaborate information to patients about the virus.

An explanation is needed regarding the type of virus, transmission, and risks. - P

Education must be complete, from prevention to prognosis. – D

When "viral infection" is mentioned, patients tend to show expressions of concern, although the virus in question sometimes only causes mild symptom and clears on its own, not Covid-19. When this happens, occasionally important points about the disease need to be re-emphasized so that the patient understands and becomes calmer. – D

An explanation of PHBS, the use of masks, physical distancing may be accompanied by a description of the virus, mode of transmission, and risk factors. – P

Limited to preventive information by avoiding to gather in crowded places (physical and social distancing), doing PHBS, wearing masks. - P

As shown by the interview results, the doctor should take a role as a competent expert (informative model) when giving Covid-19 information to the public from the patient's perspective. Changing attitudes do not always involve the same psychological process as changing behavior, and people are more likely to agree with persuasive messages (Itzchakov et al., 2018)yet social psychology is only just beginning to identify the different mechanisms involved. We contribute to this understanding by showing that the moderators of attitude change are not necessarily the moderators of behavior change. The results of three studies (Ns = 98, 104, 137. The community

was divided into two groups, some of which have implemented recommendations to comply with health protocols while the rest have not.

It takes time to change people's behavior and habits. For example, at this time, people still find it challenging to use masks, wash their hands before and after entering or leaving the room. – D

At the beginning of the Covid-19, people experienced panic fear, but what's good is PHBS is carried out well, and now finally washing hands, wearing masks, and social physical distancing have become a good habit in our society. But, now after they were initially frightened, they have turned into "just ordinary" as evidenced by the fact that many people have traveled. The #dirumahsaja appeal still applies because new normal has not been implemented in the regions. But, how can we blame our friends? Some of them leave the house to work for life. – D

Most of the people already wear masks when they go out. Hand washing stations in public facilities are easier to find. Handwashing habits have increased, and people are more health literate. – D

There is a culture of shame if you don't wear a mask. More often, apply PHBS in everyday life. Change the form of interaction, for example, from shaking hands to not shaking hands, prioritizing online interactions. – P

However, the interviews showed that it was not immediately possible to provide information to the public and change the way of life drastically. The change took place by receiving information and applying it habitually.

It had changed last month, but now it looks like it's back. – D; P

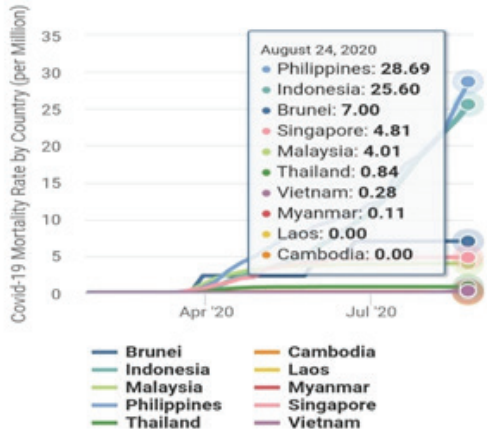
In the beginning, the streets were deserted. Since many have come to the office again and the PSBB has been relaxed, the community has become ignorant, and many have not implemented health protocols. – P

The public is bored with that news. The economic sector is not running normally. It is necessary for the law enforcement officers to take action regarding personal protective equipment (at the minimum is masks), less public transportation for workers whose income does not allow them to own private vehicles, distance teaching and learning which is burdensome for the public. In addition, the government does not have a good communication division as a mouthpiece and to carry out public relations tasks regarding Covid-19. – P

Discussion

Physicians caring for Covid-19-infected patients are at high risk of contagion and possible mortality (Ing et al., 2020). The death of a doctor while on duty is a tremendous sacrifice coupled with the possibility of them infecting another family members, and it is very worrying at this time (Zhan et al., 2020). In controlling the Covid-19 pandemic, people may feel indifferent to carry out self-isolation and realize the dangers of this virus when a doctor dies dealing with the virus.

Figure 1. Covid-19 Mortality Rate by Country in Southeast Asia



Source: Center for Strategic & International Studies, 2020

Doctor-patient interpersonal communication as health communication is only one part of the risk mitigations for GPs.

For doctors, communication cannot be separated from their daily work, because they serve patients and provide information in the health sector. Doctor-patient communication is the main thing in building trust and effectiveness regarding the information conveyed. Individuals are seen as independent communication systems that process messages by receiving, storing, and retrieving information. In this case, the cognitive process is central because it involves the perception and function of decoding discursive forms and meanings, storing and retrieving relevant information in memory, and constructing or negotiating to mean (Zoller & Dutta, 2008).

In establishing communication between doctors and patients, trust must be created on both sides so that the information from doctors to patients can be optimally conveyed and comprehended. According to Rusbult et al. in Budyatna (2011), partners build a sense of trust between one another, so an increase in dependence or mutual need for one another is expected (Budyatna, 2011). They become more familiar and intimate. Trust is an essential thing in interpersonal communication. In most cases, health history is the most critical and early information source. This will guide the doctor to perform a physical examination and later any further appropriate medical tests to determine the roots of the medical problem and arrive at a correct diagnosis.

One of the factors which increases infection risk and even death of GPs is patients who lie about their travel history (Xinghui, 2020). Changes in communication in the history-taking stage were found in this research in order to mitigate such issue. One of those changes lies in the anamnesis process, i.e. the interview conducted between the doctor and patient. It is an initial medical examination technique to collect patient's medical

data, so an approximate diagnosis of the disease can be identified. Active communication or dialogue among doctors, medical staff, and patients is necessary so that active transmission is empathic communication (Asfihan, 2019).

From the informant's answer, due to the presence of Covid-19, s/he did a reasonably detailed history-taking and some additional actions. This was discovered at the beginning of the medical interview through a "screening" process using a Covid-19 sheet. The sheet contained, more or less, questions about travel history, occupation, residential address, and history of any possible close contact with positive patients. These changes can have two effects, namely make the relationship tense or do not affect the patient.

The next communication process was carried out with a partial approach from Cegala by promoting doctor-patient communication competence during a medical consultation or interview. There is a general agreement that the exchange of information lies at the heart of medical consultation. Doctors need patient's information to make an accurate diagnosis and effective treatment plan. Patients need information about their health problems and the reasons and treatment procedures. Therefore, evaluation of information exchange is highly recommended to pay attention to information consultation, provision of information, and verification of health consultation participants.

The first group is the information-giving group. Doctors provided explanations related to disease through medical interviews with patients. From the study results, the respondents stated that communication in providing information related to diagnosis had increased. The application of differential diagnosis was necessary to establish a real diagnosis and add simple supporting examinations which were communicated with an in-depth approach to patients suspected of Covid-19. The second group is the information-seeking group. The doctors tried to find additional and related information during the medical interviews. From the field observations, the doctors' conditions of information seeking did not change significantly.

The third group is the information verification group. The doctors verified the information obtained from the patients during the medical interview. The research results showed that all hospitals mandated honesty from the patients when they gave their personal information; some even used an agreement attached by a stamp duty to ensure valid information. That kind of action was taken because in Indonesia, cases of the spread of Covid-19, which dishonest patients caused, were found in several regions. For examples are the cases in Karawang, Probolinggo to West Kalimantan.

The success of communication by doctors in serving patients should need awareness of the importance of dynamic and quality communication, and also active communication, instead of the passive one. It means interpersonal communication by the doctors is not only communication from the sender to a recipient of messages and vice versa. Rather, it is a reciprocal communication between the sender and recipient of messages (Prima, 2018).

The final group is the socio-emotional communication group. Doctors applied a socio-emotional approach during medical interviews to support the three previous processes. This is quite interesting because there are several facts about the effects of mass media and news coverage which eventually lead the patient's family to respond to the disease with anxiety.

Role of GPs in health communication and promoting pandemic issues.

A doctor, who is considered as someone competent and having credibility in the health sector, plays an essential role in conveying information. It is related to the communicator's proximity to the audience because s/he can communicate directly. The interview showed that the medical personnel, such as doctors and nurses who know for sure the causes and treatments have a high impact on society, have a place after the government, such as strict rules, fines, and sanctions (including the President/Governor), and mass media with true and positive coverage. In the current crisis, doctors play an essential role in communicating with the society. They are leaders in public health; patients, institutions, and communities depend on them for expert guidance about health consequences. They may have the opportunity to provide resources or comments to the media, hospital/clinic committees, community organizations, and elsewhere (Vance & Morganstein, 2020).

Because the general public has been overwhelmed with information related to the novel coronavirus (Tanne et al., 2020), creating those messages in an unclear way might click to attention-seeking behavior and conspiracist ideation (Wang et al., 2019). The community see healthcare workers as the parties who have some information with exact validity, e.g. information update regarding the WHO's Guideline. In other literatures, healthcare workers also have a responsibility to refute or rebut misleading health information and provide appropriate information (O'Connor & Murphy, 2020). GPs must also update correct and accurate information so that the public gets information about the pandemic's peak, its duration, and severity, which are unpredictable and unknown. There is evidence that health workers can stop the spread of fake news by rejecting or refuting misleading health information on social media and providing appropriate sources (Chou et al., 2018).

As traditional Indonesian culture dictates, we expect that religious person (clerics, priests, spiritual experts), or traditional elders/community leaders, such as RT (neighourhood association) heads or community leaders are supposed to dis-

seminate information. Or, influencers/celebrities as public figures will even have more impacts. Nevertheless, the study showed different results. Understanding the relationship between utility and cognition is vital to understand the effects of communication and social interactions on one's attitudes and feelings towards something or other people. Effective communication is essential not only to patient-related businesses in healthcare settings, such as GPs, hospitals, and clinics. GPs also have an essential part in convincing patients to always be careful and aware of this virus and PPE helps to visually and clearly (as a part too) describe the danger of infection (Ambigapathy et al., 2020).

Educating patients about Covid-19: How and What?

Technological developments in the health sector allow the emergence of public knowledge about various new diseases. However, unfortunately, health problems and illnesses are rooted in individual or environmental negligence, and ignorance and misunderstanding about the information received. For this reason, it is necessary to pay attention to the flow of health information sent and received not only by individuals but also by the public. This concern about the flow of sending and receiving health information is known as health communication (Wardhani et al., 2017).

GPs should also provide patients and families with ongoing support, education, and monitoring. The results of this study indicate that detailed information regarding prevention, transmission, and the risks posed by Covid-19 is needed. It is deemed necessary for the medical personnel to show patients and their families about risk factors (to death) which are quite worrying in Indonesia (with CFR >5%). The GPs should always ensure that high-threat fear calls are accompanied by messages of equally high effectiveness. Messages to be delivered to patients should still be tested with care to ensure that they generate an increased threat and, more importantly, perception of high efficacy (Witte & Allen, 2020). It is also necessary to cultivate the habit of a Clean and Healthy Lifestyle (PHBS) to increase the community's effectiveness and several other things, such as wearing masks, regular exercise, getting enough rest, and washing hands according to the government's recommendations.

This is consistent with the theory that people who feel unable to make specific recommendations tend to respond with fear control. Therefore, to persuade people to act, this model suggests that messages need to make people aware of threats and increase self-efficacy to reduce risks (Littlejohn et al., 2017). The first thing to ensure is to convey the right information emotionally to the patient in moderation rather than too much information. Then, gradually the information is given with a not too big unity under a catchy title. The goal is that patients do not lose the topic nor miss the news or medical narrative. Finally, ensure that the patients' values or principles are listened to during medical treatment in order to make them being felt, heard, and understood, even when the treatment plan leads to what is medically feasible.

When giving information, doctors must use PPE appropriately, apply standard protocols on triage and referrals, and provide patient-specific information about Covid-19. Using PPE is one way to minimize infections that occur to doctors and make patients understand the dangers to patients (Ambigapathy et al., 2020). AlsoFurthermore, control includes the administrative sideadministration, such as ensuring proper facilities and infrastructure, clear infection prevention and control policies, facilitated access to laboratory testing, accurate triage and patient placement, and reducing the number of doctor-to-face patients (WHO, 2020).

Then, at the clinic entrance, clear signs such as posters, pictures, and visual warnings in local and Indonesian languages are given. It should be striking enough and placed at the front in order to inform patients who fall into the category of patients under investigation (PUI). The goal is to provide early detection and notify the health workers at the triage counter or reception. PUI is a patient who has a fever or acute respiratory infection (with symptoms including shortness of breath, cough, or sore throat) and has traveled or lived in an affected country within 14 days of being sick or had close contact with a confirmed case of Covid-19 in the 14 days before the onset of disease.

Communication behavior can significantly influence patients and family members' health care decisions, even if these decisions are not based on medical quality (Tallia et al., 2006). Clinicians can use established communication principles with patients and the public to form accurate risk perceptions to prevent and reduce the impact of a costly imbalance between perceived risk and actual risk (Vance & Morganstein, 2020).

A recommendation of change on relationships between GPs and patients during the pandemic

Literature introduced four doctor-patient interaction models. The first is paternalistic model, with a focus on improving the health and well-being of patients through doctor intervention. The second is the informative model, which provides all relevant information to the patient so that the patient can choose the medical intervention he wants and to be carried out by the doctor. The next model is an interpretive model that aims to explain the patient's values and what they want and to help the patient choose the available medical interventions which are aware of these values. The last model is consensus-based model. It aims to help the patients decide on and select the best health-related values which can best be realized in clinical situations (Emanuel & Emanuel, 1992).

Doctor-and-patient health communication is a type of communication that takes place trans-

actionally through face to face. Ong stated that this communication is interpersonal and complex (Ong et al., 1995). Roter and Hall (2006) suggested four primary forms of the relationship between doctors and patients, including standard (default), paternalistic, consumptive (consumerist), and mutualistic forms (Roter & Hall, 2006). Although several studies stated that mutualistic is the best in patient-doctor communication, using pandemic as a special case, this study found that a shift in providing information was better and more effective if it was done in a paternalistic manner and informative form.

This change in the type of doctor-patient interaction resulted from initial plans to reduce the risk of infection by reducing the number of face-to-face consultations and switching to telemedicine and teleconsultation. However, even a significant shift to remote and electronic work still requires face-to-face contact with patients (Majeed et al., 2020)public health officials initially deployed interventions that were used to control severe acute respiratory syndrome (SARS. Research supported by Gao and Dong showed that tensions between doctors and patients decrease in a significant public emergency, and patients and their families trust doctors more (Gao & Dong, 2020). With increased patients' anxiety and trust, GPs should more efficiently deliver the information using paternalistic-informative to communicate with patients.

Health communication to develop behavior change and build a resilient society

Health communication is a systematic effort to disseminate health information to positively influence individual health behavior in society by using various communication methods, interpersonal communication, and mass communication (Liliweri, 2008). While health communication aims to inform and influence individual or community decisions, health communication is vital to educate the public about what concerns and how to maintain health. It is significant on the public agenda (Schiavo, 2008). In health communication, theoretical schools of thought were found, which were grouped into several approaches, namely positivistic, interpretative, critical, and cultural methods. Health involves the complexity of individual needs, motivations, and priorities (Mubarak & Chayatin, 2009). Health communication also contributes to and is a part of the disease prevention and health promotion efforts, according to the health officials or authorities (Alfarizi, 2019).

This study showed that the application of the transtheoretical model of change could be found from the pre-contemplation stage in early March 2020. When people felt overwhelmed by the threat of the virus in Indonesia, needed changes to deal with the new disease, and believed that the government's late response made them vulnerable to the pandemic (Almuttaqi, 2020), people did not intend to act immediately. The reason is, the Ministry of Health pointed out that Covid-19 was just a common disease like the flu. Besides, when other countries in the world decided on lockdown, Indonesia planned to provide stimulus measures to encourage tourism development (Almuttaqi, 2020).

Then, after the virus began to spread, they hesitated to change immediately. The community then thought and intended to change immediately because hundreds of people had died. When the threat of death is ubiquitous, the preparedness to face a pandemic lacks at the same time (Djalante et al., 2020; Gudi & Tiwari, 2020) as insufficient health services (Setiati & Azwar, 2020) and lockdown and social distancing policies to limit mobility (Satya, 2020). They were aware of the positive reasons for changing as well as the negative consequences of not changing. They made preparations for action beforehand due to the news and were not aware of the real conditions. Communities selected action plans and could engage in action-oriented programs. Finally, many individuals made changes, and these actions were proven and measurable to prevent infection from the virus. However, the challenge arose when we did not know the pandemic's final line in order to sustain the changes already made, and the society did not find the motivation to prevent unwanted behavior from recurring.

The presence of Covid-19 forces medical personnel to make changes and adjustments during the pandemic. It starts from the symbolic process, namely the process of change in terms of pre-medical examinations. The use of PPE is an obligation for the medical personnel before conducting a test. The hospital facilities which have changed function can also be easily found, such as the presence of arrival screening rooms, use and addition of isolation rooms, distance inpatient waiting areas, disinfection of surfaces before and after services, tools to wash hands before entering health care areas, to the distribution of leaflets and banners related to Covid-19 information are enforced in various health service providers. Changes in different symbolic things can be interpreted differently by each society. Meanwhile, changing health habits through massive health education is the key to stopping the spread of the Covid-19 virus.

Conclusion

Currently, infection control to prevent the spread of SARS-CoV-2 is the primary intervention used. However, public health agencies must continue to monitor this situation closely because the more we know about this new virus and its associated outbreaks, the better we will respond to them. The analysis came to the following conclusions: the medical consultation process undergo some changes, more time is needed to examine the Covid-19 screening list, and some adaptation processes are also necessary – we suggest that the mode of communication is changed into the paternalistic-informative model. In addition, our

results on how to communicate various health conditions are consistent with the fear approach. We do not suggest or even conclude that communication skills alone will be a silver bullet for doctors' moral pressure, fatigue, and anxiety in the face of Covid-19. However, we believe that communication is only one part (although it is an essential part) of what doctors need to survive this pandemic.

Acknowledgments

We would like to thank the Ministry of Information and Communication of the Republic of Indonesia for granting the scholarships and the Ministry of Finance of the Republic of Indonesia for permitting the study assignments.

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