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Original Research Article

Barriers to Effective Communication Between Medical Students and Adopted Families Under the Family Adoption Program: A Qualitative Study in Rural Bihar

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Abstract:

Background: Under the Competency-Based Medical Education (CBME) curriculum, the Family Adoption Program (FAP) was implemented with the goal of enhancing undergraduate medical students' empathy, communication skills, and community orientation. In order to accomplish these goals, medical students and adopted families must communicate effectively. However, meaningful relationships may be hampered by structural, societal, and educational limitations, especially in rural areas. Comprehending these obstacles is crucial to enhancing the program's execution and results.

Objectives: To investigate and comprehend the obstacles to efficient communication in a rural field practice region between medical students and adoptive families participating in the Family Adoption Program.

Methods: Between July and September of 2025, a qualitative study was conducted in the rural field practice area associated with the Department of Community Medicine at Nalanda Medical College in Patna. Data was gathered through four Focus Group Discussions (FGDs) with medical students and ten In-Depth Interviews (IDIs) with members of adopted families. The subjects were selected through the use of purposive sampling. An inductive theme analysis was performed on the verbatim transcription of the audio recordings.

Results: Language hurdles, cultural disparities, a lack of mutual trust, time restrictions, perceived power imbalances, students' inadequate orientation, and families' limited comprehension of FAP's goals are just a few of the obstacles to effective communication that were identified by thematic analysis. Interactions were further impacted by gender-related communication difficulties, emotional reluctance, and fear of being judged. Despite these obstacles, families and medical students both indicated a desire to increase participation if sufficient assistance and direction were given.

Conclusion: Complex interpersonal and contextual factors impact communication between medical students and adopted families under FAP. The program's efficacy can be increased, and better student-community ties can be fostered by addressing these obstacles through organized training in communication skills, cultural competency, and community sensitization.

Keywords: Family Adoption Program; Medical Education; Communication Barriers; Qualitative Study; Community Medicine; Rural Health.

Introduction

As it enables students to comprehend the social, cultural, and environmental determinants of health while honing critical clinical and communication skills, community-based medical education has been acknowledged as an integral part of undergraduate medical education [1]. In rural and disadvantaged communities, where health behaviors and access to care are influenced by deeply ingrained sociocultural variables, exposure to real-life community situations is typically restricted by traditional hospital-based learning. The Competency-Based Medical Education (CBME) curriculum, which emphasizes early clinical exposure, community orientation, and the development of soft skills like communication, empathy, and professionalism, was introduced by the Medical Council of India now replaced by the National Medical Commission in order to close this gap [2].

Under the CBME framework, the Family Adoption Program (FAP) was designed as a long-term community involvement project in which medical

students are paired with certain families and have to stay in touch on a regular basis for a predetermined amount of time. Students are supposed to learn about family dynamics, health-seeking behavior, lifestyle choices, and the influence of social determinants on health through frequent interactions. Families also gain from better connections with health providers, early detection of health issues, and heightened health knowledge [3]. This program's foundation is effective communication since trust-building, accurate information gathering, and appropriate health education all depend on meaningful discourse.

Language proficiency, cultural norms, educational background, socioeconomic level, and interpersonal dynamics all have an impact on the intricate and multifaceted process of communication in the healthcare industry [4]. Language or dialect barriers, gender roles, traditional beliefs, and differing perspectives on sickness and medical professionals can all make it more difficult for medical students and community people to communicate in rural Indian settings [5]. When interacting with families outside of the clinical setting, medical students especially those in their early training years may also feel nervous, insecure, or unsure of their role. These elements may restrict candid communication and lessen the efficacy of student-family relationships.

Communication is also greatly influenced by power relationships and perceived social hierarchies. Because they may see medical students as authoritative figures, families may be reluctant to ask questions, voice concerns, or divulge private information for fear of being misunderstood or judged [6]. On the other hand, students can find it difficult to strike a balance between cultural norms and professional boundaries, which could result in relationships that are either too formal or too informal. Sustained and meaningful communication may also be hampered by time constraints associated with academic burden, a lack of community engagement orientation, and a lack of supervision during field excursions [7].

There is little qualitative data examining the lived experiences of medical students and adopted families within the Family Adoption Program, especially in eastern India, even though communication is essential to its success. Most previous research has concentrated on how students view community-based learning or quantitative evaluations of program results, paying little attention to the complex interpersonal difficulties that arise in real-world interactions [8,9]. To improve training materials, bolster faculty support, and guarantee that the program meets its intended educational and public health goals, it is essential to comprehend these obstacles from the viewpoints of both students and families.

Qualitative research methods, such as Focus Group Discussions and In-Depth Interviews, are particularly well suited to explore complex social processes like communication, as they allow participants to articulate experiences, emotions, and contextual factors in their own words [10]. By capturing diverse perspectives from medical students and adopted families in a rural field practice area, this study aims to generate in-depth insights into the barriers affecting effective communication under the Family Adoption Program. The findings are expected to inform curriculum planners, educators, and policymakers on strategies to enhance student preparedness, community engagement, and the overall impact of community-based medical education [11].

Aim and Objectives

Aim: To investigate the obstacles to successful communication in a rural community context between medical students and adoptive families under the Family Adoption Program.

Objectives

1. To identify student-related factors influencing communication with adopted families.
2. To explore family-related and sociocultural factors affecting student–family interactions.
3. To understand contextual and program-related challenges encountered during the implementation of the Family Adoption Program.
4. To generate insights that may inform strategies for improving communication and community engagement within community-based medical education programs.

Materials and Methods

Study Design: In order to investigate obstacles to successful communication between medical students and adopted families, this study used a qualitative research approach that included Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs). In order to provide a comprehensive knowledge of the experiences, perspectives, and contextual elements influencing communication under the Family Adoption Program, a qualitative method was deemed appropriate.

Study Setting: The study was carried out in the rural field practice area of Sabalpur village in Patna, which is connected to the Nalanda Medical College's Department of Community Medicine. Undergraduate medical students taking part in community-based activities as part of the Family Adoption Program are trained in this area.

Study Duration: The study was conducted between July and September of 2025, a span of three months.

Study Participants: Members of families adopted by undergraduate medical students participating in the Family Adoption Program in the chosen rural field practice region were also study participants.

- **Focus Group Discussions (FGDs):** Four FGDs were conducted with medical students who were actively participating in the Family Adoption Program. Each FGD consisted of 6–8 students to allow adequate interaction and discussion.
- **In-Depth Interviews (IDIs):** Ten IDIs were conducted with adult members of adopted families who had regular interactions with medical students as part of the program.

Sampling Technique: Participants who were knowledgeable and had firsthand experience with the Family Adoption Program were chosen using purposive sampling. To guarantee significant insights, medical students with at least three months of field experience and family members who interacted with students on several occasions were included.

Data Collection Tools and Techniques: Semi-structured interview guidelines created independently for FGDs and IDIs were used to gather data. Open-ended questions about interaction experiences, perceived communication difficulties, cultural and societal influences, program expectations, and suggestions for improvement were all included in the guides. To go deeper into responses, probing questions were employed. Every FGD and IDI was held in a language that the participants found comfortable, mostly Hindi with sporadic usage of regional dialects. With prior permission, audio recordings of conversations and interviews were made, and field notes documenting nonverbal clues and contextual observations were added.

Data Collection Procedure: In order to ensure privacy and minimal disruption, focus group discussions (FGDs) with medical students were held in a quiet environment on college property or in the field practice area. IDIs with family members took place at their residences or another mutually agreeable spot in the community. IDIs lasted from 30 to 45 minutes, but each FGD lasted roughly 60 to 90 minutes. Until thematic saturation was reached and no new ideas emerged from further conversations or interviews, data collection continued.

Data Analysis: When necessary, verbatim transcriptions of audio recordings were translated into English. To guarantee correctness and familiarity with the data, transcripts were examined several times. An inductive method was used to do the thematic analysis. The transcripts were used to create the first codes, which were subsequently categorized and grouped into more general themes that represented obstacles to successful communication. To improve rigor and consistency, the analysis was iterative and constantly compared across FGDs and IDIs.

Ethical Considerations: The Institutional Ethics Committee of Nalanda Medical College in Patna granted the study ethical permission. Before any data was collected, all participants provided written informed consent. Personal identifiers were eliminated from transcripts and reports to ensure confidentiality and anonymity. Participants were made aware that their participation in the study was entirely voluntary and that they might leave at any time without facing any repercussions.

Results

Thematic analysis was used to examine the qualitative information gathered from ten In-Depth Interviews (IDIs) with adoptive family members and four Focus Group Discussions (FGDs) with medical students. Six main themes and numerous subthemes emerged from the analysis, which collectively describe the obstacles to efficient communication under the Family Adoption Program (FAP). In order to improve transparency and analytical rigor, descriptive quantification was employed to show the prevalence of codes and themes throughout FGDs and IDIs, despite the study's qualitative nature. Since they are inappropriate for qualitative research, no inferential statistical tests were used.

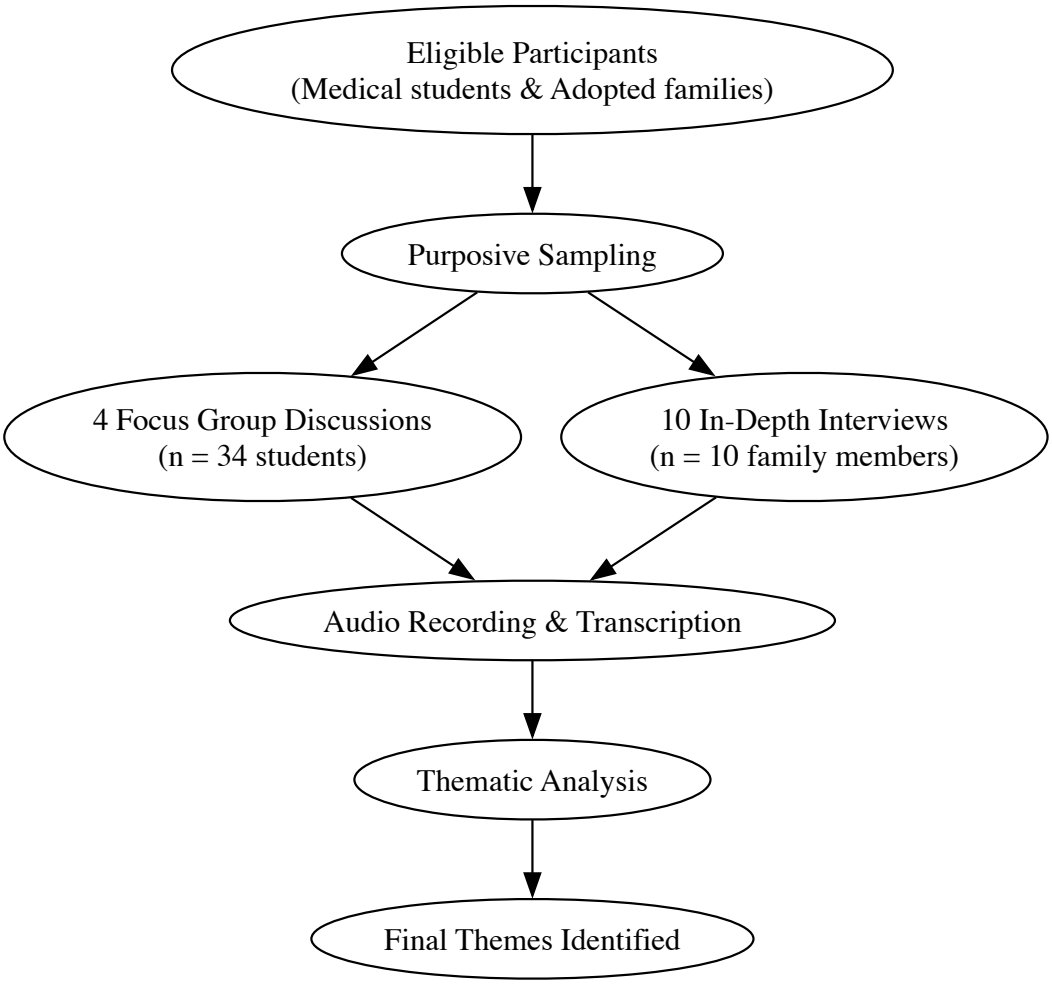

Figure 1: Flow diagram depicting participant recruitment and data collection process in the qualitative study.

Participant Characteristics: In all, 34 medical students took part in four focus group discussions (FGD-1 through FGD-4), with eight to nine students in each group. Adult family members from adoptive households, representing a range of age groups, vocations, and educational backgrounds, were among the 10 IDI participants.

Table 1: Profile of Study Participants

Participant Group	Number	Gender Distribution	Additional Characteristics
Medical students (FGDs)	34	18 male, 16 female	Undergraduate students enrolled in FAP
Adopted family members (IDIs)	10	5 male, 5 female	Homemakers, daily wage workers, farmers, elderly dependents

Overview of Emergent Themes

The thematic analysis identified the following six major themes:

1. Language and linguistic barriers
2. Sociocultural differences and belief systems
3. Trust deficit and fear of disclosure
4. Perceived power imbalance and role ambiguity
5. Time constraints and academic pressure
6. Inadequate orientation and program-related challenges

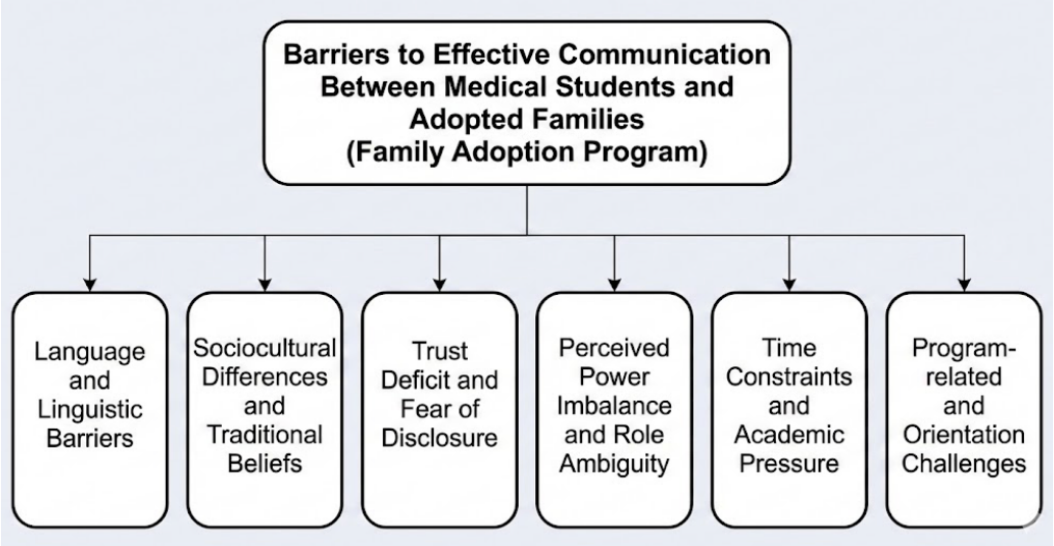

Figure 2: Thematic framework illustrating major themes and subthemes influencing communication between medical students and adopted families

The distribution of these themes across FGDs and IDIs is summarized in Table 2.

Table 2: Frequency of Major Themes Identified Across FGDs and IDIs

Theme	FGDs (n=4)	IDIs (n=10)	Total Mentions
Language barriers	4	8	12
Sociocultural differences	4	7	11
Trust deficit	3	9	12
Power imbalance	4	6	10
Time constraints	4	3	7
Program-related challenges	3	5	8

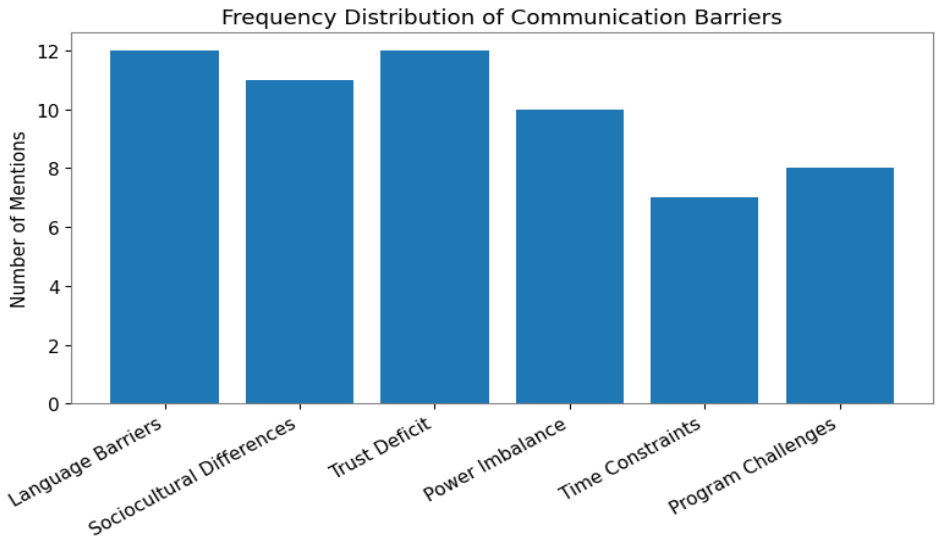

Figure 3: Frequency distribution of major communication barriers identified across FGDs and IDIs.

Theme 1: Language and Linguistic Barriers: One of the most often mentioned obstacles to successful communication is language. Family members indicated problems comprehending medical terms, while medical students reported having trouble speaking in the local vernacular. While many families preferred local dialects, students frequently depended on Hindi, which resulted in exchanges that were shallow and only partially understood. Families said they were reluctant to ask inquiries for fear of coming out as ignorant.

Illustrative Quote (IDI): "Sometimes we do not understand what they say, so we just nod our head."

Illustrative Quote (FGD): "We try to explain, but converting medical ideas into simple village language is difficult."

Theme 2: Sociocultural Differences and Traditional Beliefs: Communication patterns were greatly influenced by cultural norms, health beliefs, and customs. When talking about preventative health measures, particularly those pertaining to gender roles, nutrition, sanitation, and reproductive health, students ran against opposition. Elderly guidance and conventional treatments were frequently given precedence over student recommendations by families. Open communication between male pupils and female family members was restricted by gender conventions.

Table 3: Sociocultural Barriers Identified by Participant Group

Subtheme	FGDs	IDIs
Traditional health beliefs	✓	✓
Gender-related hesitation	✓	✓
Resistance to behavior change	✓	✓
Preference for local healers	✓	✓

Theme 3: Trust Deficit and Fear of Disclosure: Family members were more likely to voice concerns about trust. Many families saw students as transitory guests or outsiders, which made them reluctant to divulge private details about family problems, financial hardships, or chronic illnesses. Open communication was further hampered by concerns about confidentiality and fear of being judged.

Illustrative Quote (IDI): "We don't know what they will write or tell others."

Students acknowledged that repeated visits improved familiarity, but trust-building required time and continuity.

Theme 4: Perceived Power Imbalance and Role Ambiguity: Medical students were often perceived as authoritative figures despite their trainee status. This power imbalance led families to adopt a passive role during interactions.

Students themselves expressed uncertainty regarding their scope of responsibility, oscillating between being learners and perceived healthcare providers

Table 4: Perceptions of Role and Authority

Perception	Students (FGDs)	Families (IDIs)
Students as doctors	✓	✓
Fear of giving wrong advice	✓	–
Hesitation to question students	–	✓

Theme 5: Time Constraints and Academic Pressure: Medical students were the ones who most frequently mentioned time-related obstacles. The length and frequency of household visits were constrained by a heavy academic burden, exam schedules, and several curriculum commitments. As a result, there were less chances for deep conversation because interactions were frequently task-oriented rather than relationship-based.

Illustrative Quote (FGD): "Sometimes visits become a formality because we have exams and postings."

Families also noticed irregular visits, which affected continuity and engagement.

Theme 6: Inadequate Orientation and Program-Related Challenges: Families and medical students both identified program orientation gaps. Before being exposed to the field, students thought that their training in communication skills, cultural awareness, and community engagement was insufficient. Families stated that they had little knowledge of the goals and advantages of the Family Adoption Program, which resulted in inflated expectations or disinterest.

Table 5: Programmatic Challenges Identified

Challenge	FGDs	IDIs
Lack of communication training	✓	–
Poor community sensitization	✓	✓
Inconsistent supervision	✓	–
Unclear expectations	✓	✓

Discussion

In a remote area in Bihar, the current qualitative study investigated obstacles to efficient communication between medical students and adopted families under the Family Adoption Program. The results demonstrate the complexity of

communication issues in community-based medical education, which are influenced by language, sociocultural, interpersonal, and programmatic factors. If these obstacles are not removed, the program's instructional value for students may be limited, and its potential impact on community public health may be diminished.

In line with previous qualitative research in rural and semi-urban Indian settings, where dialect differences and low health literacy have been demonstrated to obstruct meaningful interaction between healthcare providers and community members, language emerged as the primary barrier [12]. Families were reluctant to ask questions for clarification out of embarrassment, and medical students frequently found it difficult to interpret medical principles into language that was understood locally. Similar findings have been documented in community-based learning initiatives, where insufficient linguistic adaptation resulted in surface-level interactions rather than dialogic communication [13]. The significance of teaching students contextualized health communication instead of only biological information is highlighted by these findings.

Families' receptivity to student-led interactions was significantly impacted by sociocultural views and traditional health practices. Recurring issues in this study were gender norms influencing communication, resistance to preventive recommendations, and dependence on local healers. Medical students who attend rural communities frequently come across belief systems that diverge significantly from biomedical paradigms, which can cause conflict or disengagement if not handled tactfully, according to prior study [14]. The above results highlight the necessity of cultural competence training as a crucial component of the Family Adoption Program to assist students in efficiently and respectfully navigating these differences.

Among adopted families, fear of disclosure and a lack of trust were especially prevalent. Concerns about judgment, secrecy, and the transient nature of student involvement were voiced by families. Similar trust-related issues have been reported in long-term community programs, where participants were hesitant to provide private or sensitive information to students who were seen as authority figures or outsiders [15]. During program implementation, it is important to stress continuity, recurrent encounters, and explicit communication about the aim and bounds of data gathering in order to create trust.

Student-family relationships were made more difficult by perceived power disparities and unclear roles. Families frequently saw students as physicians or agents of the healthcare system, despite the fact that students saw themselves as learners. This resulted in passive communication and little inquiry. Previous research on early clinical exposure has demonstrated this mismatch, with imprecise role description leading to irrational expectations and communication obstacles [16]. Aligning expectations and lowering hierarchical obstacles could be facilitated by organized orientation meetings for both family and students.

Students' main concerns, which limited the depth and regularity of participation, were time limits and academic pressure. Similar limitations have been documented in competency-based curricula, where meaningful community participation is hampered despite the curriculum's goal due to conflicting academic obligations [17]. While brief, task-oriented visits could satisfy documentation needs, they don't promote rapport-building or reflective learning. This problem might be lessened with institutional support in the form of faculty mentorship and protected time for community events.

Lastly, programmatic weaknesses included a lack of community sensitization and insufficient orientation. Families were unclear about the goals and advantages of the Family Adoption Program, and students felt unprepared for communication difficulties in the real world. Previous assessments of community-based medical education have highlighted the importance of community awareness and program ownership in addition to student preparedness for successful implementation [12–17]. By filling in these gaps, the initiative's sustainability can be improved and mutual participation strengthened.

Overall, the conversation shows that good communication under the Family Adoption Program is a complicated interaction influenced by systems, culture, and environment rather than just a skill-based problem. The program's educational and societal results can be greatly enhanced by addressing these obstacles through organized communication training, cultural competency modules, precise role description, and community sensitization.

Conclusion

This qualitative study demonstrates how a complex interaction of linguistic, sociocultural, interpersonal, and program-related factors affects medical students' ability to communicate effectively with adoptive families under the Family Adoption Program. The quality of relationships in rural community settings is greatly impacted by obstacles such language barriers, deeply ingrained cultural views, a lack of mutual trust, perceived power imbalances, time limits, and inadequate orientation of both students and families.

Despite these obstacles, the results also show that families and medical students are willing to participate in meaningful ways when given the right assistance and direction. Existing deficiencies can be filled by strengthening training in communication skills, boosting cultural competency, defining student roles explicitly, and increasing community awareness. To optimize the program's instructional value, institutional measures including structured supervision, protected time for community interaction, and ongoing feedback systems are crucial.

By removing these obstacles, the Family Adoption Program can promote trust, health consciousness, and cooperative connections within the community in addition to enhancing communication and empathy among aspiring medical professionals. Such initiatives are essential to the long-term viability of community-based medical education and to ensuring that medical education is in line with rural people' health needs and reality.

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