COMMUNICATION BETWEEN HEALTHCARE WORKERS AND ISIZULU SPEAKING FEMALE PATIENTS AT THE SCOTTSVILLE CLINIC, PIETERMARITZBURG, SOUTH AFRICA

by

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Submitted in partial fulfilment of the requirements for the degree of Masters of Information Studies (MIS) in the Discipline of Information Studies, School of Human and Social Studies, University of Natal.

UNIVERSITY OF NATAL, PIETERMARITZBURG

2000

DECLARATION

I hereby declare that the whole thesis, unless specifically indicated to the contrary in the text, is my own original work and has not been submitted for a degree at any other university.

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M. B. NIBA

NOVEMBER 2000

DEDICATION

This work is dedicated to God Almighty; who, by His grace and love, stood as my rock and fortress

ACKNOWLEDGMENTS

The accomplishment of this research work has been by the constant and genuine co-operation of many persons.

Special gratitude goes to my supervisor, Athol Leach, and to the Director of Programmes, Prof. Andrew Kaniki, for their meticulous corrections and contributions to the project.

I also wish to thank Dr. Chris Ellis, Mr. M. Legese and the entire staff of the Discipline of Information Studies, for proof-reading the work and making vital contributions.

Special mention must be made of my parents, Elizabeth and Mfombe Nyamboli, my sister-in-law, Baboni Angelica, my beloved Christian friends, Rashida and Collin, and my entire family, for their prayers and financial support.

The medical staff of Scottsville Clinic and the patients who willingly responded to the interviews and questionnaires.

Finally, I am greatly indebted to my beloved husband, Augustine Suh Niba, for his support and prayers and for sponsoring the work.

ABSTRACT

This study sought to establish some of the problems that occur during a consultation process between a healthcare worker and a patient, such as intangible and tangible verbal/nonverbal communication problems. Tangible nonverbal problems refer to eye contact, gestures, body posture and facial expression. Tangible verbal problems refer to voice tone/attitude and language and intangible to race, age, gender, education and culture. It was made clear that the problems involved in the consultation process were, in the main, common to other forms of communication such as that between a reference librarian and a client, customer, visitor or user.

The factors that hindered communication were investigated by means of semi-structured interviews and questionnaires. The sample population was made up of 100 black isiZulu-speaking females and seven healthcare workers of a heterogeneous background. The perception of the respondents in relation to the above-named factors (language, age, gender, attitude, culture, education, gestures and postures) was sought.

The analysis of the results obtained showed that some of the significant factors that are a problem in communication include voice tone/attitude, eye contact, sitting position, gestures, facial expression and language. Patients, for the sake of effective concentration and free flow of information, preferred healthcare workers who were polite, had a cheerful demeanour and who sat still and straight up (not looking around or standing). This is noted because the

majority of the patients acknowledged such healthcare workers and were not satisfied with those who behaved otherwise. For example, in relation to previous consultations (irrespective of the Clinics), out of the 70 respondents who encountered problems, 61 (87%) in despair cited cases of rudeness, of which the majority of such cases related to African healthcare workers. Culture also mattered, when seen in terms of people being able to speak the same language and understand one another, with respect to the contextual meaning of words. As far as eye contact was concerned, it was apparent that adjustments had been made. For example, it was discovered that although it is the Zulu culture to avoid eye contact, especially between the young and the old, Zulu people have come to accept eye contact in a cross-cultural South Africa. Their acceptance was also seen as due to the advantages of eye contact. This was made clear by the fact that of the 90 (91%) respondents who acknowledged the fact that the healthcare workers maintained eye contact during the consultation process, 87 (97%) said it was polite as it gave them the assurance that the healthcare workers were paying attention to what they were saying.

Among the socio-demographic variables investigated, the gender of the healthcare worker emerged as one of the important predictors of effective communication. This is because the majority of the respondents indicated feeling freer with someone of the same gender grouping.

Certain recommendations were made which were considered vital in improving not only the consultation process but any other form of communication, including that between a reference librarian and a client. The main recommendations were that the healthcare workers be polite and endeavour to speak the main language as the patients. Due to the fact that some healthcare workers hurry during consultation, it was recommended that more staff be employed.

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CHAPTER ONE

1 INTRODUCTION

1.1 Introduction

Transfer of information can take place in different ways, for example, in print, whereby information is obtained through the reading of books, pamphlets or journals. Information can also be transferred orally or verbally, where one can get a one- or two-way transfer of information; the former referring to an individual, for example someone in authority, addressing a group of people, while the latter refers to a one-to-one communication (interpersonal communication). The one-to-one communication can, for example, be between a healthcare worker and a patient, a reference librarian and a user, or a husband and wife. However, for such communication to be effective, certain techniques need to be applied and certain barriers taken care of. These techniques and barriers are in the main, common to a one-to-one communication process, irrespective of the parties concerned. For example, the technique of "user-centeredness" whereby the satisfaction of the patron is top priority in the communication process (Jennerich and Jennerich 1997), applies to both the reference librarian and user and the healthcare worker and patient. Furthermore, barriers caused by factors such as language, age, education, gender and cultural differences need to be taken into account in the one-to-one communication process as a

whole. In general, if the techniques are applied and the barriers are handled well, effective communication will take place, leading to the effective transfer of information, irrespective of the parties involved. To be more precise, an information manager or a healthcare worker, for example, wishing to engage in one-to-one communication with a patron or a patient, needs to repackage the information to be communicated in such a way that the patron will be able to have a firm grasp of it. Stilwell (1999: 42), suggests that " the rationale behind the term repackaging is 'making information available to illiterates' and other groups for whom the usual format used for conveying the information would pose a barrier to access". These barriers could include scientific and technical terms, all needing some form of repackaging whereby if a patron is illiterate or semi-literate, information could be repackaged in the form of posters. If the subject matter is condoms, for example, posters displaying the use of condoms could be prepared. With respect to such repackaging, Sturges and Chimseu (1996: 90) give an example of Malawi, where the Ministry of Health, through its health unit, creates information material to address different information needs. The material varies from posters to leaflets and booklets on health matters, in different languages. These, to an extent, breaks the barrier of educational disparity (with imagery and symbolism) between the parties involved in a communication process. Nonetheless, repackaging alone may not guarantee effective communication. This is because the patron may assume either as an individual or as a group that condoms are a matter for the Western world and not for her/his culture. Such a barrier or mind set needs to be addressed for effective communication, and thus effective

transfer of information to occur.

The present research focuses on communication between a healthcare worker and a patient, with the intention of unraveling the communication problems involved and suggesting necessary solutions. Examples will be drawn from the situation of a reference librarian and a user. As Sturges and Neill (1998:79) maintain, "Community needs and problems interlock, and cannot simply be separated into packages called health, work, development, etc." Moreover, it can be argued that the consultation process between a healthcare worker and a patient can serve as a good example of a communication process that can be directly extrapolated to other forms of communication as between the reference librarian and the user.

1. 2 Background

1.2.1 Health sector and the Scottsville Clinic

In South Africa in 1995 there was widespread agreement in the health sector for the need to develop a better functioning district health system. The health system in the Greater Pietermaritzburg area was, at the time, functioning in a very fragmented and inefficient manner (*Greater Pietermaritzburg reconstruction project* 1995). Taking the Clinics as an example, J. Sithole (the Deputy Chief for Community Health Nursing, Pietermaritzburg), commented on the limited boundaries of the municipalities in the past, whereby the

Clinics were mainly in the city areas. She holds that the boundaries have now been extended to embrace 20 Clinics, including those in townships such as Edendale and Northdale. These Clinics operate on a small scale in communities, providing separate services on different days of the week. The location of the Clinics depends on the population density.

Scottsville Clinic is an example of the small scale clinic mentioned above. The Clinic is opened for consultation three days a week; Tuesdays (between 8 a.m. and 3 p.m.) and Fridays (between 8 a.m. and 12 midday) for the general public with Thursdays (between 8 a.m. and 12 midday) being for the elderly. By 11.30 a.m., especially on Thursdays and Fridays, patients are no longer admitted to the Clinic (though at times they are admitted beyond 11.30). This means that any patient who arrives after 11.30 a.m., or on days not mentioned above, does not receive medical attention. The Clinic has six healthcare workers who are qualified nurses. The nurses are all females and are Indians, whites and blacks, of different age groups. The Clinic offers a comprehensive service, including primary healthcare, immunization, family planning, legal aid, social work and home visits. The nurses diagnose and prescribe. Emergencies and complicated cases are referred to hospitals. The service is free of charge, as is any medication dispensed. Patients come from different races including Indians, blacks, whites and "coloureds". However, the black isiZulu speakers are the majority, accounting for a ratio of approximately 5:1 (of the other races). Females are in the majority, accounting for a ratio of approximately 20:1

(male). The ages of the patients vary from babies to those well over 40 years of age. Their educational levels also vary from those having no education to some with doctoral degrees. Home languages include the aforementioned isiZulu, as well as English, Afrikaans and others such as French. Patients' occupations vary from housewives and domestic workers to professionals such as teachers and nurses.

1.2.2 Communication process

The principal language spoken in the province of KwaZulu-Natal is isiZulu, followed by English and Afrikaans. Indian, Zulu, and Afrikaans traditions give an interesting cultural mix in the province. In examining the prevalent situation in South Africa and, as Hutcheson (2000:997) states, the chief characteristic of South Africa's population and the one that dominates its society is the great racial, linguistic and cultural heterogeneity of its people with blacks, Asians, whites and mixed race citizens all displaying different cultural traits (healthcare workers and patients inclusive). Given the history of the apartheid system, the most important effect of the system had been the unequal provision of education, whereby millions of people received very little or no formal education and education of a very low quality (*Greater Pietermaritzburg Reconstruction Project* 1995). It is also stated in the Project that about 50% of the population of Pietermaritzburg are functionally illiterate (having insufficient knowledge and skill in writing and reading to function adequately). All these elements are in one way or the other closely linked to the communication process, including that between the healthcare worker and patients. Given

the various elements above, namely racial, linguistic, educational and cultural heterogeneity, much information can be lost in a medical interview (as well as in any other interaction such as a reference librarian and a user), especially where the healthcare worker (reference librarian) has difficulties in understanding what the patient (user) is saying and *vice versa.*

As Cicourel (1987:77) states:

> the physician and linguist face similar problems; how to make visible, those aspects of discourse and textual materials that seem to be intended, implied or misleading...(that) the patient finds it difficult to follow the physician's language and often tacit or even explicitly, specified symbolic recoding. The patient's literacy or rationality, even if he or she is highly educated, is no match for the physician's language and external memory system; a system that is in constant tuning if the doctor is able to keep up with new developments in medicine.

To communicate freely, both the healthcare worker and the patient need to be familiar with the communication process and the factors involved. As illustrated in *Figure 1* below, the process includes a source, a message, a channel and a receiver (*Communication handbook* 1983:5).

Source ⇨ Message ⇨ Channel ⇨ Receiver

Figure 1. Simple model showing the basic steps in communication

Source : This can be a person, or a "situation" that initiates a message. The operation of the source is determined by a number of elements, for example communication skills,

attitude toward the subject and one's self, and the ability to think, write, speak and draw. The socio-cultural context, which demands knowledge of the subject, situation, audience, social background, education, friends and salary, influences the way the source operates (*Communication handbook* 1983). Given these elements, communication then becomes complex. Taking the medical setting as an example, Ellis (1999) asserts that any illness or accident can be ascribed to supernatural forces, however trivial they may seem to the doctor. He also states that beliefs may vary remarkably from group to group and individual to individual, even about specific causal theories. Looking at universal health beliefs, Ellis holds that Western patients may believe in hormonal imbalances, clean air and they may even believe in the doctor. People with traditional beliefs may not just be interested in their illnesses, but also in who made them ill. This is due to the association of certain illnesses with spiritual forces and ancestors. The source (which can be the healthcare worker) therefore needs to be sensitive to the patient's socio-cultural context and frame of reference, while bearing in mind anomalies in cross-cultural context. An example of such anomalies can be noticed in an individual who, coming from a traditional background where certain illnesses are attached to spiritual forces, acts differently by not believing in any of the normal causes of her/his illness. Belief systems are therefore important to any human interaction, including the search of a user for information from a reference librarian.

Message: This refers to the package to be sent by the source. The accepted code or the language needs to be selected for use. The code needs to be convenient to both parties, enabling the information to flow freely, without ambiguities. For example, if the source (the healthcare worker) needs to initiate a conversation or pass across a message to the receiver (the patient), she/he needs to use the appropriate code or language. In doing so, the source (healthcare worker) should bear in mind that within this language there are other codes, as pointed out by Boadi (1987:5), who made it clear that, even when the language, for instance English, is appropriate for use, other codes such as those relating to scientific or technical terms, as well as format considerations, pose as barriers. To be more precise, if a healthcare worker is to communicate with an English speaker, then the appropriate language will be English, if to an uneducated patient or a patient not versed in the medical language, then a simplified language (terminology broken down to the level or understanding of the patient) needs to be used. However, in the selection of the code, the source (healthcare worker) is not to focus solely on the convenience of the receiver, but also on her/his convenience. This refers to the fact that, whatever language is appropriate to the receiver (patient), the healthcare worker should use it, *if* she/he can speak the language fluently.

Channel: This can be the senses (sight, hearing, smell and touch). The senses play a vital role in communication. For example, for communication to be effective, there is need to look at the party being addressed, to listen, perceive and act on what is said and to

physically touch her/him, as deemed necessary. Grogan (1991: 89) elucidates more light on this by saying that an interview must not just be a process of information exchange, but a social act involving a human face (human bond).

Receiver: This is the final link in the communication process and could be a person or persons who make up the audience (*Communication Handbook* 1983). The satisfaction of the receiver is important as it stands as the main determinant of a successful communication. This is to say that the "source" derives its satisfaction from that of the "receiver". Taking the case of a healthcare worker and a patient, competent service with cordiality, contributes to the satisfaction of the patient. The latter, when satisfied, makes it possible for the source to be satisfied as well.

With respect to the communication process (from source to receiver), communication experts agree on four points: firstly, that human communication is not just a process, but an on-going and a dynamic one; secondly, that the process is irreversible and original impressions cannot be erased; thirdly, someone's perception is important in a communication process, for example a patient may perceive the look of a healthcare worker to be unfriendly and finally, communication takes place within a situational context *(Communication handbook 1983)*. It should be noted that although the communication process is projected above as one-way (from the source to the receiver), it can also be a two-way process, for example, from the healthcare worker or librarian to

the patient or user and *vice versa*. This two-way form of communication is what is examined in the present research and it involves the oral form.

1.3 Statement of the problem

Personal observation shows that complaints relating to medical consultations are registered not only because of poor treatment, but also because of a lack of inter-intelligibility between healthcare workers and patients. This could partly be due to language and other socio-demographic differences between the patient and the healthcare worker. Examples of such socio-demographic factors are age, gender, education, socio-economic status and the beliefs, moods or psychological states of the patient and the healthcare worker. Shuy (1979:18) says that the state of the patient, be it that of uncertainty or anxiety, can magnify pain. Likewise, the healthcare worker's poor knowledge and/or usage of communicative skills in which she/he will have to probe for information from the patient, as well as her/his poor knowledge of the socio-cultural background of the patient, can block her/his understanding of the "non-medical" problems that affect patients. Here, the patient (user) presents a unique story and the healthcare worker (or reference librarian) analyses, it making sure that all the information is interpreted (hermeneutics). This information-gathering process, is in turn, accompanied by an explanation whereby the healthcare worker must explain to the patient what is going on and the patient is then left to interpret the explanation within the context of her/his knowledge and culture. Ellis (1999) holds that the healthcare worker has a

'scientific discourse style' which is more factual and less fanciful, whereas the patient may have a 'narrative discourse style', which is more fanciful and of a story-type nature. People in general, have personal discourse styles, some being highly imaginative and others not. In all these different styles, Ellis says that there is an element of a social power relationship, where the healthcare worker holds the knowledge and the information, thereby having the "position power" and the patient away from home in a strange environment (the Clinic), is at a disadvantage.

Given the above situation and the heterogeneous state of the healthcare workers and patients found in South African communities such as those who visit the Scottsville Clinic, the occurrence of communication problems is likely. However, it is worth noting that the situation is not necessarily peculiar to the Scottsville Clinic, but also to other, similar communities in South Africa and elsewhere. One could argue that such a situation is prevalent in communication settings in general. For example, between a reference librarian and a user, differences in "position power", culture, language and social status can impact on the communication process, if not well handled. Poor or ineffective communication can result in poor assessment or analysis of the actual information needs of the user. In the medical setting, such a situation can lead to medical complications and eventual disability, or death in extreme cases. Wrong words or concepts used can also have serious consequences in extreme cases. Thus, for a disease to be correctly diagnosed, effective communication between healthcare workers and patients is

imperative. Likewise, in any other setting be it between a reference librarian and a user, for a query to be properly assessed, effective communication is imperative.

It is evident from the above discussion and from the review of literature (Chapter Two) that very little has been done in the South African context to identify the factors which either impede or facilitate effective communication between healthcare workers and patients. It is this problem which the present study seeks to address.

1.4 Research purpose

The purpose of this research is to undertake a study of communication between healthcare workers and patients, with a view to identifying some of the problems which occur during the consultation process and contribute to ineffective communication. These problems could be tangible (verbal/nonverbal) or intangible, as defined by Jennerich and Jennerich (1997). Tangible refers to clear, definite and real situations and intangible refers to situations that are not definite but are indirectly influential. Verbal can be perceived in terms of words and nonverbal in terms of actions. Examples are thus:

- Tangible nonverbal

  Eye contact/culture, gestures, body postures and facial expressions.
- Tangible verbal

  Voice tone/attitude and language
- Intangibles

Race, age, education, gender and culture

(The above are discussed in more detail in Chapter Two).

Given that a one-to-one communication can have any setting, the results of the research are expected to help whoever is involved in such communication, for example those in the Library and Information Sector (LIS) who are involved in the exchange of information, including reference librarians. The setting for this research is medical, however, and involves healthcare workers and patients because the situation brings out and exemplifies the problems so well.

1.5 Research objectives

- To establish the key tangible verbal communication problems encountered by healthcare workers and patients during consultation.
- To establish the key tangible nonverbal communication problems encountered by healthcare workers and patients during consultation.
- To establish the key intangible communication problems encountered by healthcare workers and patients during consultation.
- To make recommendations based on the findings.

1.6 Research questions

The following research questions emerged from the objectives listed above:

- What are the key tangible verbal communication problems encountered by healthcare workers and patients during consultation?
- What are the key tangible nonverbal communication problems encountered by healthcare workers and patients during consultation?
- What are the key intangible communication problems encountered by healthcare workers and patients during consultation?
- What suggestions or recommendations can be given, based on the findings?

1.7 Assumption

In the collection of data the researcher assumes that the patients are likely to recall what transpired during the consultation process if contacted immediately after the medical interview.

1.8 Justification

It can be argued that with the urgent call for information transfer and with limited resources, the need for evaluation and accountability in the healthcare service is of increasing importance. Ineffective communication may lead to serious consequences in extreme cases. For example, poor communication between a healthcare worker and a patient can result in wrong diagnoses and eventually in money being spent on the wrong

medication. Wrong medication can, result in further complications, or loss of life. Similarly, poor communication between a reference librarian and a user can lead to inappropriate analysis of the required information needs of the user. This could result in incorrect sources of information, which could cause frustration on the part of the user. Communication, therefore, is as important as the recognition of symptoms and the cure of the related diseases.

The patient, just like any other user, should be an active participant in constructing her/his understanding of the situation in place. As explained by Felicia (1997: 4345), this is because "Both physicians and patients contribute to the final decision regarding appropriate and efficacious ... treatment, yet ... there has been no detailed linguistic study of this crucial phase of doctor-patient interaction". Felicia's assertion that such a contribution is crucial is backed by the fact that compliance in terms of treatment relies upon a solid channel of communication between the provider and the user. The solid channel encompasses the roles of "expert" and "novice" deployed with the tools of everyday language practice. Here the giving and receiving of expert medical advice and information from both parties is essential. However, if the 'communication cable' is severed, patients might succumb to the interplay of poor communication and, ultimately, to noncompliance (Felicia 1997: 4345).

Naude (1997:371) makes reference to the experience of Professor Oliver Ransome, who has been an ombudsman in South Africa since 1996. Ransome states that, of all the complaints concerning medical communication, the vast majority had been about perceived negligence on the part of doctors, where the side-effects following medical procedures had not been adequately explained to the patient. There were also reports of rudeness and poor attitude shown by the doctors. Naude states that the criticism received by the medical ombudsman could have been avoided by better communication between the doctors and their patients.

The present research seeks to investigate aspects of communication in the medical field. It is believed that research of this nature, which brings to light those hidden aspects of life that may affect communication in the medical setting and in other areas such as the library and information sector (particularly the reference interview), is a worthwhile undertaking. Such topics have not been adequately studied in South Africa. Much has been written world-wide about communication in general and medical interviewing in particular. However, it was also noted that most of what had been written (in the medical setting), elaborated more on the different factors that either impede or facilitate the disclosure of the results of a diagnosis. For example, healthcare workers were sometimes unable to communicate grievous results to the patient. Another main area of research was observed in the investigation of factors such as culture/beliefs. These might affect a patient's acceptance of the results of her/his diagnosis and the prescriptions therefor. Examining

the issues that might affect the actual consultation process (prior to the diagnosis), it was discovered that little research had been done in the South African context. The literature search which led to these conclusions was done by contacting institutions such as the Medical Faculty in Durban. It was also done on-line, using packages such as South Africa Bibliographic and Information Network (SABINET), the South African National Bibliography (SANB), Humanities Citation Index, Science Citation Index, Social Science Citation Index, Library Literature (LL), Humanities Abstracts, Dissertation Abstracts Ondisc, the EBSCOhost Web and National Information Services Corporation (NISC). Not much was found of direct relevance to the present study, thus stressing its importance.

1.9 Limitations

Due to time and financial constraints, the research is limited to one municipal Clinic, in Scottsville, Pietermaritzburg, KwaZulu-Natal province. Many factors impede communication in general and that in the medical field in particular. These factors are also viewed in many and varied ways. Some of the factors include attire, mood, psychological state, education, language, attitude, age, gender, socio-economic status, culture, religion, blindness, deafness, dumbness, madness, time, distance, workload, colour (race), greetings and question negotiation (Ntonifor 1985). While acknowledging these different factors and the different ways in which they are viewed, the study cannot investigate them all and is further limited to some of the tangible verbal and nonverbal aspects of the medical consultation as well as some of the intangible aspects.

These are tangible nonverbal components (eye contacts, gestures, postures and facial expressions); tangible verbal components (voice tone/attitude and language); intangibles (culture, social status, age, gender, race and time).

1.10 Definition of concepts

1.10.1 Communication

The term communication is a subject of much controversy. Nevertheless, to best understand the factors that surround the medical consultation, knowledge of what communication means and entails is necessary. Foskett (1975:6) sums up communication as " a psycho social linguistic act or performance in which a system, though formed in the mind of one human being, is transferred and assimilated into the mind of another .... A basic factor in the process of assimilation .... is recognition." For example, a complicated message using medical terms will mean little to the person who has no medical training, and the simplest isiZulu expression will mean even less to a person who understands only French. For assimilation to be possible, information should be repackaged in a form easily recognized by the receiver.

Oomkes in *International course on rural extension* (1990:5) defines communication as "the exchange of symbolic information that takes place between individuals, who are aware of each other's direct or mediated presence".

Samovar, Porter and Jain (1981:13-14) look at communication as having both intentional and unintentional elements. They thus assert that

> Communication is defined as a two-way, on-going, behaviour-affecting process in which one person intentionally encodes and transmits a message through a channel to an intended audience in order to induce a particular attitude or behaviour. Communication is complete only when the intended receiver perceives the message, attributes meaning to it and is affected by it. In this process must be included all conscious or unconscious, intended or unintended verbal, non-verbal, or contextual stimuli that act as cues to both the source and receiver about the quality and credibility of the message. We must also realize that although we are concerned primarily with intentional communication situations, behaviour that may be perceived as messages may be generated without intention.

For the purpose of the present study, communication is defined as a process of encoding and decoding information in a given situation using an appropriate code. The situation could be a discourse or a dialogue between a librarian and a library user or a healthcare worker and a patient. Envisaging communication in this light means attributing certain norms or factors which may either promote or prevent the free flow of information, irrespective of the stated rules in place. These factors could be tangible (verbal or nonverbal) or intangible.

1.10.2 Culture

Culture, depending on the context, is viewed differently by different authors, thus making the notion of it complex. However, as defined in the *Chambers 21st Century dictionary* (1999: 327), culture is "customs, ideas, values, etc. of a particular civilization, society or

social group, especially at a particular time". As reflected in *The cultural identity of Cameroon* (1988:168) it is the "life-giving spirit of civilization, which must advance, develop and transform, at the pain of disappearing...." It is known as a product of self. As such, it is common to regard self as a cultural object and to examine the cultural or environmental factors that lead to the expression or inhibition of certain aspects of the self (Mota 1997: 7).

Ellis (1999: 61) defines culture as "the body of shared attitudes, values and habits that is conveyed by a society to its members". Hence culture constitutes an individual's basic orientation that enables her/him to act in an intelligible manner (Lock 1981). According to Slonim (1991), cultural norms prescribe solutions to life's basic problems and provide stability and dynamics for people responding to changing life situations. However, Slonim (1991) warns that individuals of the same culture do not necessarily think and act in the same manner. They often share different standards as a result of age, gender, beliefs, attitudes, education, occupations and social levels. Rack (1982) elaborates more light on this by pointing out the following:

- Each person's value system is a result of experiences.
- Values differ from one society to another because of different learning experiences.
- Values are relative to the society in which they occur.
- No values are universal, though values of each culture need to be respected and

human beings probably have some universal values for survival.

Looking at the extremes, individuals with unique behaviour are oft-times identified. They are regarded by Slonim (1991) as "idiosyncratic", "queer" or "crazy" (exhibiting deviant behaviour).

Cross-cultural psychology is another important aspect of culture. It is defined by Heelas (1981) as a statement about the nature of a person and her/his relationship with the world. The statement contains rules and advice about the way people should behave, feel and how they can achieve success and happiness in life. In this case, culture can be interwoven with health beliefs, as they both come from a hybrid of one's personal, family, community and national affiliation. Samovar, Porter and Jain (1981:24-25) clarify this by saying that

> Culture manifests itself in patterns of language and in forms of activity and behaviour that act as models for both the common adaptive acts and styles of communication that enable us to live in a society within a given geographic environment at a given state of technical development at a particular moment in time. It also specifies and is defined by the nature of material things that play an essential role in common life. Such things as houses, instruments and machines used in industry and agriculture, forms of transportation, and instruments of war provide a material foundation for social life.

In the communication process, participants bring with them differing backgrounds which have been instilled in them by the different cultures to which they belong. In a multi-cultural society like South Africa's, these backgrounds can be vastly different especially

because within a culture there are subcultures (economic, racial, ethnic, social or regional) that manifest certain peculiar patterns of behaviour which can be distinguished from others within a macro-culture.

For the purpose of this study, culture is seen as constituting an individual's basic orientation that enables her/him to act intelligently. This orientation must give room for flexibility with respect to advancement, development and transformation. Values held by individuals are seen as relative to their societies. However, individuals of the same culture do not necessarily think and act in the same way. The standards often differ as a result of factors such as age, gender, attitudes, education, occupation and social status.

1.10.3 Interview

Conroy (1986:88) defines an interview as

> A form of communication which involves two ... people in an intimate setting at least one of whom has a definite communication purpose...All the persons involved both speak and listen ... Interviews may be for the purpose of getting or giving information or both... To be successful, an interview must involve participants who collaborate in seeking and giving information pertaining to a common goal. Effective interaction is necessary to accomplish the goal and ... effective one-to-one interaction depends upon the building of a relationship and rapport.

From the definition it is observed that an interview is similar to a consultation and a communication process. A consultation like an interview or a communication process, is defined in the *Chambers 21st Century dictionary* (1999) as an act of seeking information

or advice from someone who acts as a consultant. The main purpose of receiving and/or giving information is to meet an information need such as a health need in the case of a patient. For this need to be met, one can argue that a common code, the right attitude, an understanding and acceptance of the cultural norms and other differences of the participants should be taken into consideration. Effective co-operation from the parties involved is essential in meeting the need.

Given the similarities between an interview and a consultation process, the terms will be used interchangeably in the present study.

1.10.4 Language

Language is defined in the *Chambers 21st Century dictionary* (1999) as a system of sounds and words used by human beings to express their thoughts and feelings. It is also defined as the words and phrases used by a particular group or profession, for example the language of science or medicine. Furthermore, language is seen by Samovar, Poter and Jain (1981: 49) as

> ... an organized, generally agreed upon, learned symbol-system used to represent the experiences within geographic or cultural community. Each culture places its own personal and individualistic imprint on a word symbol. Objects, events, experiences, and feelings have a particular label or name solely because a community of people have arbitrarily decided to so name it. Thus, because language is an inexact system of symbolically representing reality, the meanings for words are subject to a wide variety of interpretations. In fact, it is often stated that meanings are in people rather than in words.

From the above definitions, one can argue that things that are symbolic require some form of affiliation (interpreting material relative to a broader theoretical, historical, cultural or political framework) for them to be understood. One needs to give thought to the context in which the images and texts are created and to their history (Kelly 1999: 410). Kelly further indicates that linguistic images need to be looked upon as reflecting a particular historical, socio-cultural and political context, as well as acquiring something in the context of speaking. The different contexts allow possible meanings to unfold.

Ellis (1999:1), referring to the medical consultation in a cross-cultural setting, maintains that the healthcare worker should be able to convey messages that make sense to the patient and likewise receive from the patients messages that make sense. In this case it is not just a question of language, but of metaphors, idioms, slang, euphemisms, circumlocutions and mumbling. There is also the language of respect, fear and evasion to directness, which can even cause a story to be told differently depending on who it is being told to. Ellis (1999:47) describes an incident that took place in Tygerberg Hospital in which a patient was sent to the ophthalmology clinic by a sorting sister because the patient complained of not having 'seen' her period for three months. The word 'seen' was not in connection with an eye problem but with menstruation. He also describes the Zulu custom in which a woman is not to address her husband or father directly and has to avoid using the radical of the father or grandfather-in-law's name. For example, if the father's name is Thomas, words such as tomatoes should be avoided.

Ellis (1999) holds that language can be influenced by fashion, spelling and pronunciation as well and can differ or change from one generation to another and from one village to the next.

Language is a complex issue and recognizing its different components is vital. A patient (or whoever is involved in a communication process) who feels her/his world is understood is more likely to respond to an intervention (Ellis 1999:2).

In this study language is seen as a system of symbols, words, sounds and gestures, used for conveying information through the effective understanding of the same language (isiZulu, English, Afrikaans and others and including the appropriate body gestures) and through familiarity with the language of the profession concerned (medical language). For example, a patient who can express her/himself freely in isiZulu should be able to communicate effectively with a healthcare worker who can express her/himself freely in isiZulu. In addition, the two parties should be able to understand the medical language being used. There should be awareness of the different cultures and individuals concerned, because the meaning of words can be subject to a wide variety of interpretations.

1.10.5 Education (literacy)

Education is defined in the *Chambers 21st Century dictionary* (1999) as the process of

nourishing or rearing a person in preparation for the work of life. Literacy (functional literacy), as defined by the United Nations Educational, Scientific and Cultural Organization (UNESCO), in *Greater Pietermaritzburg Reconstruction Project* (1995), entails having knowledge and skill in reading and writing, by which means an individual can engage effectively in activities in which literacy is normally assumed in her/his culture group. The concept is more complicated in a multi-lingual society such as that of South Africa. In such situations, people can be literate in the vernacular such as isiZulu but will have difficulty in coping with the demands of living, for example in KwaZulu-Natal, where a fair level of basic literacy in the English language is required. Moreover, for people to be able to communicate effectively, they need not only share the same language, but need to be familiar with the vocabulary pertaining to the group(s) concerned. As such, the level of understanding of the two parties in a communication process such as a medical consultation, is an important element.

1.10.6 Healthcare worker

A healthcare worker is anyone engaged in health services be they public or private. In the context of the present work, the term means anyone engaged in health services and who is involved in a consultation process. The worker might be a doctor or a professional nurse who interviews a patient for the purpose of diagnosing a medical problem. Given that municipal clinics do not have doctors, in this study, the term healthcare worker refers to a professional nurse.

1.11 Summary

This Chapter served as an introduction outlining the background of the work and also the problems, purpose, objectives, assumptions, justification and limitations of the research. The definitions of concepts are provided for purposes of clarification. It is stressed in the Chapter that the heterogeneous nature of the healthcare workers and patients found in South African communities such as those who visit the Scottsville Clinic is likely to cause communication problems. Poor or ineffective communication can result in wrong diagnoses and treatments which, in turn, can lead to complications and eventual disability or death in extreme cases. For an illness to be well diagnosed, effective communication between healthcare workers and patients is essential. The objectives of the research were to investigate the key tangible verbal and nonverbal communication problems, as well as intangible nonverbal communication problems encountered by healthcare workers and patients during consultation. It was emphasised that one-to-one communication problems are similar in different settings, be they between a reference librarian and a user or a healthcare worker and a patient. This research is assumed to be of potential benefit not only to those in the medical profession, but to those working in the library and information field as well.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

As indicated in Chapter One, little research has been done in South Africa into issues that might affect the actual consultation process (prior to the diagnosis) between a healthcare worker and a patient. It was also noted that the literature search behind these discoveries (including the literature reviewed in this Chapter) was done by contacting institutions such as the Medical Faculty in Durban. It was also done on-line, using packages such as South Africa Bibliographic and Information Network (SABINET), South African National Bibliography (SANB), Humanities Citation Index, Science Citation Index, Social Science Citation Index, Library Literature (LL), Humanities Abstracts, Dissertation Abstracts Ondisc, the EBSCOhost Web and National Information Services Corporation (NISC). The literature concerning communication in general, and in the medical setting in particular, was examined. The literature deemed relevant to the present study is presented in this Chapter. The first part covers general considerations about communication-based problems, with particular focus on the reference interview (communication process between a reference librarian and a user with the intention of getting the required information need of the latter, analyzing the problem and helping her/him meet that need). The second part on the other hand, involves discussion of work

directly related to the subject of the study.

2.2 General considerations about communication-based problems

2.2.1 Components of communication

The reference interview is a challenging and fascinating process, given that verbal and nonverbal factors influence it, as well as attitudes, dress, the environment, the colour of the furniture, lighting and race (Katz 1982: 41). These factors, if not well handled, can lead to a lack of or ineffective communication, irrespective of the logical rules (getting the information needs of the patient, diagnosing the problems and providing prescriptions). Katz (1982: 16) claims, that perfect information does not make for perfect understanding or correct decisions. He holds that even though human behaviour in general, and decision making in particular, cannot really be scientifically described, incorrect decisions have been made due to misunderstanding of some of or the greater part of, the information delivered. In medical communication, just as in other forms of communication, much is lost in a medical interview mediated by an interpreter, where the doctor has difficulty in understanding what the patient is actually saying (Ncayiyaya 1999: 907). The message to be communicated, must be clear and should need no translation to be understood. The sender should ensure the recipient's thorough grasp of the message (Katz 1982: 16).

Grogan (1991: 89) holds that the librarian-enquirer interview must not just be a transfer of information, but a social act, no matter how brief. Interpersonal communication requires a human face (or a human bond), where the librarian needs to take cognizance of observations, such as uneasiness of the user because she/he feels uncomfortable in the library. Jennerich and Jennerich (1997) consider a successful reference interview that in which the user feels satisfied that the interviewer has given her/him undivided attention and has provided a competent service, even if the required information needed is not provided for one reason or the other, such as the information not being available in the format wanted by the user.

Jennerich and Jennerich (1997) also refer to the tangible and intangible components of communication. The former involve verbal and nonverbal skills. The verbal skills consist of remembering, avoiding premature diagnoses, reflecting feelings verbally, restating or paraphrasing content, using encouragers (such as "well done"), closing, giving opinions and asking open questions. Verbal communication encompasses the use of language and the patterns of thought, all manifesting themselves in the person's ability to externalize her/his thoughts through speech (Behrens 1990:92). The nonverbal skills embody eye contact, gestures, postures, facial expressions and voice tone. Dodd (1987) opines that nonverbal communication is highly culture-specific. Although different cultures could produce similar nonverbal behaviours, each culture could have entirely different interpretations for the behavioral cues.

Below is a more detailed reflection of the tangible verbal and nonverbal components of communication, as explained by Jennerich and Jennerich (1997). These components relate mainly to the reference interview in libraries, but are useful for informing the investigator of the communication process at the Scottsville Clinic.

2.2.1.1 Tangible components

Jennerich and Jennerich (1997:13-17) highlight the two main divisions of the tangible components to reflect the verbal and nonverbal skills employed in a communication process.

2.2.1.1.1 Verbal skills

The relevant aspects of the verbal skills, as discussed by Jennerich and Jennerich (1997), involve the following:

2.2.1.1.1.1 Remembering

Remembering requires the librarian to listen, in order to put things together. For example, from the information provided by the user, be it in an organized or disorganized manner, the reference librarian, by listening carefully, should be able to tell, that the user is in need of a specific kind of information, for a specific subject, within a specific region and time and for a specific purpose.

2.2.1.1.1.2 Avoiding premature diagnosis

Premature diagnosis means making assumptions about the user or query before all the necessary information is given. This occurs mostly when a librarian becomes more proficient at interviewing and has known the user for some time. Judging a user's social status, level of sophistication or intelligence mainly on appearance can lead to unproductive results. For example, a well-dressed user can be mistaken for an intelligent, "all-knowing user". Such a perception can cause the reference librarian to take things for granted, such as not explaining in detail certain terminologies and processes which are necessary for getting the required information. The needs of a user must be well evaluated and appropriate means applied to meet the needs of that user.

2.2.1.1.1.3 Reflecting feelings verbally

The issue of reflecting feelings is a controversial one among librarians. According to some librarians, trying to understand and reflect the feelings of a user requires much counseling and does not permit sufficient time for professional reference work. For example, a user, in the course of presenting an information need, may take excessive time explaining the frustrations she/he has gone through in searching for that information. This may lead the reference librarian to tend to over-sympathize and concentrate on those frustrations. Jennerich and Jennerich (1997: 14) feel that successful interviews can be conducted without this skill.

2.2.1.1.1.4 Using encouragers

Encouragers involve responding to a user with words or short phrases for encouragement. Examples are "So?", "Tell me more", "Give me an example", "Well done". This keeps the user talking until her/his need is fully satisfied with the necessary details.

2.2.1.1.1.5 Asking open and closed questions

Open questions require answers which go beyond 'yes' or 'no' responses. They give the user unlimited choices in responding. However, to formulate them on the spot requires expertise. Thus if they are pre-planned and written down it will be easier for the reference librarian to browse through them and present them to the user. Sometimes the inquirer does not ask a final or complete question. The reasons for this is that they have not consciously expressed in their minds the information needed. This may lead to a feeling of uneasiness, as the user feels condemned for not knowing what she/he thinks she/he is supposed to know. Open questions, coupled with an atmosphere of relaxation may help the user to explain further. On the other hand, asking closed questions limits the dialogue, as the respondent is given limited choices. However, they do help in achieving specificity.

2.2.1.1.1.6 Giving opinions and suggestions

Librarians should avoid statements such as 'if I were you, I would....' because such statements deal with the actual problem and not with the means of finding the information. To solve the problem, suggestions or guidelines should be given as to what

source or agency should be contacted. In addition, it can be argued that the function of the librarian (unlike that of a medical person) is not to interpret or evaluate legal, medical or business matters for the user.

2.2.1.1.1.7 Closing

Interviews may have to be terminated for various reasons, such as time of day, number of people waiting and cost. Whatever the reason, it is not polite to close an interview midway through it. There are various ways in which an interview can successfully be closed as explained by Jennerich and Jennerich (1997: 15):

- Informing the user of what is needed for continuing interview.
- Encouraging the user to return for further help.
- Referring the user to someone or something more beneficial.
- Asking if the user is satisfied in terms of her/his need being met.

Jennerich and Jennerich(1997) then elaborate on the different relevant aspects of the nonverbal skills.

2.2.1.1.2 Nonverbal skills

2.2.1.1.2.1 Eye contact

Eye contact is considered by Jennerich and Jennerich (1997) as a powerful tool in the

reference interview. The two parties concerned should have eye to eye contact during the interview. However, cultures and individuals differ. The fact that American culture requires eye contact is cited by Behrens (1990:93) as an example of such differences. Behrens gives an example of the Zulu culture, in which eye contact is avoided as a sign of respect; a Zulu son would not gaze directly into his father's eyes for an extended time during communication. In an interview, there is the possibility of encountering users who, out of respect for the elderly (as reflected in her/his culture), will avoid eye contact. Nonetheless, Jennerich and Jennerich (1997) hold that, whatever the case, the librarian should attempt to maintain eye contact. To do this, the librarian should make provision for both her/himself and the user to be at reasonably close range, in order to avoid the one straining to look at the other. Depending on the set-up of the environment, she/he can stand if the user is standing, or provide a seat for the user if she/he (the librarian) is sitting.

2.2.1.1.2.2 Gestures

Gestures used in interviews need to be appropriate to the circumstances. For example, a shrug of the shoulders and a nod of the head should match or be appropriate to what is being said. It can be very confusing if a librarian nods her/his head in spite of not agreeing with or not understanding the user. People at one time or another unconsciously manifest certain distracting gestures such as nail biting, hair twisting, pencil tapping and jaw pulling. Gestures should be curtailed in order to avoid distraction. Gestures made by

users should be ignored by the librarian, however.

2.2.1.1.2.3 Posture

A relaxed posture is preferable to a stiff, ill-at-ease appearance, especially on the part of the librarian. The user's interest is increased when there is a slight leaning toward her/him, as opposed to leaning back. Crossing the arms aggravates the leaning back posture.

2.2.1.1.2.4 Facial expression and voice tone

In the case of users manifesting certain disturbing traits such as getting restless and emotional, the librarian is expected to avoid reflecting anger and frustration, but rather to show empathy and sincerity. A humorous remark made by the user should possibly be appreciated with a smile. Concern should be shown when the patron is worried or sad. The tone of the voice should be appropriate. The librarian should sound concerned even when saying "I can see you are lost". This is to avoid any form of misconception by the user, who may otherwise consider such remarks provocative.

The above analysis of the tangibles and intangibles, as raised by Jennerich and Jennerich (1997), brings to mind Katz's (1969:16) comment mentioned earlier that "perfect information does not make for perfect understanding or correct decision". It is understood that human behaviour in general, and decision-making in particular, cannot really be

scientifically described, given that every individual is unique and has her or his own style. Even librarians have different perceptions or images that they want to project of themselves. In any case, it has been noticed that wrong decisions have been made due to misunderstanding or misconceptions of some part of a communication process. For that reason, whatever the difference or perception projected by the librarian, it must fit within the context of the situational image that is more compatible with the style of the institution, in order for a successful interview to take place (Jennerich and Jennerich 1997:10). An example is given by Jennerich (1997), who posed as a normal user and took the normal user approach to the library whereby a request is made to the reference librarian. Jennerich told the reference librarian she was looking for a book on flying and the librarian just turned around and started punching on her key board. When Jennerich noticed that the librarian was going to get the wrong material, she said she was actually looking for information on jet lag. The reference librarian kept on punching and then told her there was nothing on jet lag and wrote down a number referring her to a book on how to fly a light aircraft. Jennerich's conclusion was that the reference interview was the epitome of almost all possible deficiencies. One should be careful, however, of citing isolated cases because it may just be a question of irresponsibility of a single individual and thus should not be generalized. Nonetheless, much can still be revealed by the behaviour of an individual in terms of her/him being an example of a poor interviewer who carries out premature diagnoses of an information need.

2.2.1.2 Qualities of an interviewer

Green (1976: 78) emphasizes the qualities of a reference librarian (an interviewer) as being those of "a courteous disposition, sympathy, cheerfulness, patience and enthusiasm". Green continues by saying that the librarian should "mingle freely with the users and help them in every way to gain respect and confidence ...[so that] they find [the reference librarian] easy to get at and pleasant to talk with"(Green 1976: 78). Bacon (1902: 929) describes a reference librarian as being "approachable, tactful (and)...possessing a sense of humor". Wyner (1927: 58) lists certain techniques which the librarian should adopt in the reference interview:

- never act or look annoyed or indifferent
- never look or seem too busy to be interrupted
- meet all-comers more than half way
- meet the public as you will want to be met
- never be patronizing or openly amused
- seek out the floundering individual and offer help.

The above qualities and techniques have much bearing both on a reference interview and on a medical consultation. This is because "Relevant content must be supported by appropriate presentation if information products are to have [the] desired impact. The content might be right but if the presentation is inappropriate then [the] communication process will not be successful" (Mchombu 1992: 29).

2.2.2 Cultural and community awareness

Keller (1996:29) makes it clear that "By developing ... cultural awareness, community relations, expertise and marketing skills, libraries and librarians can enhance their value as information centres and specialists". He states that the need for a new approach to community relations is necessary, partly due to demographic changes in communities. These include millions of immigrants dispersed around the different nations (including South Africa). The ability to work in such culturally diverse settings then becomes a matter of concern. Keller (1996: 30) refers to an open letter to a colleague by the former American Library Association President, Patricia Class Shuman:

> The American dream is dreamt in a diversity of colors and myriad languages. America's right to know depends on this country's ability to understand our own and other cultures. Knowing more about each other does not guarantee a more tolerant, understanding or educated society. It is a prerequisite.

The American dream is not so different from the South African dream, given the cultural diversity of both societies. The South African dream manifests in other forms such as in ethnocentrism, lack of empathy and trust, and low self-esteem. Ethnocentrism is seen by Behrens (1990:91) as an act of superiority, exercised by groups of individuals or an individual over other groups or individuals. Examples given are those of whites looking down on blacks, Indians and Coloureds and Zulus looking down on other black ethnic groups. People are influenced by their personal ethnocentrism which manifests itself in the belief that their own culture is the best. It often results in negative stereotyping of other cultures. Stereotyping refers to overgeneralized, oversimplified or exaggerated

beliefs of a group of people (Samovar, Porter and Jain 1981:122-123).

Empathy refers to the ability to put oneself in the shoes of another and experience or understand things from that person's point of view. Lack of empathy can come about as a result of "constant self-focus", as one is consumed by one's own thoughts (Samovar, Porter and Jain 1981:197). It can also come about as a result of having stereotyped beliefs about other races or cultures or by not being familiar with those races or cultures.

Mistrust is a lack of confidence or credibility felt by one person for another (Behrens1990:91). Samovar, Porter and Jain (1981: 195-196) assert that both verbal and nonverbal messages can relay confidence and mistrust. According to Behrens (1990:91), inhibited interracial and inter-cultural social contact in South Africa can make trusting more difficult in interpersonal communication.

This issue of diversity is further developed by Low (1996:146) who asserts that the present role of public libraries (just as any other information providers, such as in the medical setting) is to help people find the information they seek, regardless of their age, educational level, socio-economic background, command or knowledge of the English language and appearance. As communities face greater ethnic and language diversity, librarians (similar to healthcare workers) are faced with the challenges associated with the serving of patrons from a multitude of cultures, many with limited or no command of the

English language. Reference librarians (and healthcare workers) will have to become knowledgeable about the different cultures, customs and beliefs, for they will be confronted by them in their libraries (or medical units) on a daily basis. They will have to be sensitive to the cultural protocols to be observed when serving users of specific cultures. They will also need to become experts in cross-cultural communication, as well as becoming multi-lingual. Finally, they will need an additional cadre of culture specific or multi-cultural, subject-related, ready reference tools at their fingertips.

2.2.3 Oral communication as a tool for meeting the needs of the community

The community is seen by Kaniki (1999:193) as "...people who share common social practices and concerns arising out of ethnicity, class, age, gender, educational achievement and lifestyle". According to Kaniki, needs may differ between persons or groups of persons, depending on a variety of factors or variables that may be grouped into categories, one of which is "information seeker centeredness", which includes variables such as demography, education, age and social and economic background. In this light, the nature of the packages into which information is placed then becomes crucial in the provision of information services to the whole community.

As a communication process and one which does not exclude the literate population, Sturges and Neill (1998: 212) see the oral form as an essential tool in reaching the semi-literate and illiterate population. This is supported by Leach (1999), who conducted a

study in which twenty-two representatives from twenty Non-Governmental Organizations (NGOs), whose work entailed information provision to adults in rural KwaZulu-Natal, were interviewed. The focus of the interview was on how the NGOs provided information to such adults. The respondents listed a wide range of subject areas in which they provided information to adults in rural areas. These included health, AIDS and HIV awareness. The respondents identified oral or verbal means in the provision of information on either a one-to-one or group basis as one of the most used mediums. However, some weaknesses of the one-to-one approach were identified, such as it being time-consuming and not reaching many people. Nonetheless, in as much as the provision of information on a group basis was the main focus some of the respondents saw the one-to-one communication as "a very effective way of transferring information especially as some people may be shy or timid to ask questions in a group". What surfaced frequently in the study as a whole were the issues of "communicate", "participate", "two-way process", "engagement" and "learning process", which are essential in a verbal communication whether it is on a one-to-one or a group basis. However, as Stilwell (1991: 114) laments, "The library service has become identified with buildings rather than with people", referring to the fact that information providers need to be highly "people-centered".

2.2.3.1 Oral communication in courts of law

Looking at communication in courts of law in Cameroon, Ngala (1988) and Kangkolo

(1989) stressed the importance of effective exchange of information, as well as the factors that hamper such exchange. The writers proposed solutions with respect to the various problems identified in their research. In the courts of Nkambe, in Cameroon, Ngala (1988) highlighted the difficulty of communication by referring to the heterogeneous background of the participants, who had different languages, races, educational levels and religion. This heterogeneity served, according to his findings, as the main handicap to communication. Other handicaps discussed by Kangkolo (1989) were poor understanding of English legal jargon by the majority of the people who go to the courts and the French and English legal systems operating concurrently.

These problems were, however, not without solutions. According to Kangkolo (1989):

- Professional training should be provided by the government to translators in courts.
- Court officials should attend nation-wide or international seminars and conferences on linguistic problems related to the courts.
- Shy or timid litigants should be heard in camera, or taken into the magistrate's chambers, where he/she can easily and freely voice his/her grievances.

Kangkolo (1989) proposed that, for "... interaction to be unproblematic, the appropriate code or language understood by both participants must be chosen".

The heterogeneous background of participants, as well as the question of language differences in a one-to-one communication such as the one identified above (magistrate-litigant), is not uncommon in the medical setting. Based on the researcher's own observations, the patients and the healthcare workers at the Scottsville Clinic portray such differences, thus warranting the researcher to investigate their effect on the consultation process.

2.3 Communication specific to the medical field

Regarding communication in the medical field, it is often said that "Medicine is a critical area of language and public life" (Shuy 1979:18). This is so because as already mentioned, poor communication can result in wrong diagnosis and treatment which, in turn, can lead to complications and in extreme cases to eventual disability or death. Effective communication between the doctor and the patient is therefore critical. The doctor's communicative skills in which he/she will have to extract information from the patient is no less important than his/her other abilities (Shuy 1979).

Cousins (1989:134-138) sheds more light on these points by saying that

> full communication between patient and physician is indispensable for an accurate diagnosis... If a physician can connect a sense of challenge instead of a grim forecast to a serious disease, a patient's own resources may be mobilized as part of the total treatment strategy.

Taking into consideration the importance of language and effective communication, Shuy (1979: 4) laments "a language policy in medical practice has high visibility but low comprehensibility ... The linguistic study of doctor-patient communication suffers from isolation from the co-operation of physician's themselves". Shuy then raises a number of factors responsible for the inadequate recognition of the importance of language in medicine:

- The problem of women and the minorities or the downtrodden patients (who cannot express themselves properly, particularly in the language of medicine. The issue is not given sufficient attention).
- Nurses make greater strides toward dealing with day-to-day communicative issues than higher status physicians (doctors).

Solutions suggested by Shuy (1979) to the above problems are:

- an increased recognition of language and
- the linguist (just like any other information provider) should make it a duty to use language understandable to the public. This can be done through language

awareness campaigns on radio and television (Shuy 1979:4).

Looking at socio-cultural beliefs in medical communication, Corlien (1991) describes the health system as "A set of cultural beliefs about health and illness that form the basis for health-seeking and health-promoting behavior...". Consideration of socio-cultural beliefs is imperative for effective interviewing. This is because the society is made up of people with different perceptions of life. Some may perceive evil spirits as the cause of their illness, while others may consider genetic or natural occurrences as being responsible. Such perceptions are confirmed by Corlien (1991:235):

> if biomedical health care is a recent introduction, people may accept services, but the beliefs and knowledge to support this behaviour may not have been fully developed. Health workers therefore should be aware of the indigenous explanations for illness, so that 'biomedical' explanations can be adapted to these more deeply rooted indigenous concepts.

If healthcare workers are not aware of these socio-cultural beliefs of patients, poor diagnosis, treatment and possibly eventual death or disability might result.

Cicourel (1981:72) also referring to beliefs, points out that

> the knowledge base beliefs of the patient can be a significant limitation for answering the physician's questions, just as the doctor's limited knowledge of socio-cultural and psychological issues can lead to a failure to recognize non-medical problems that affect illness.

Closely related to these beliefs is the background of the patients. The background situation, which is defined by Hermon (1972:493) as the "...mood or psychological state which impinges on the ongoing activity", is another relevant aspect of medical communication. This nonverbal aspect of communication, when neglected, can be disastrous. Hermon (1972:494) holds that "The less the background obtrudes, the more likely is the person to be responsive to the demands of the immediate situation".

Communication in the medical field has certain binding rules. These rules serve as guiding principles for effective exchange of information between doctors and patients. Lennard and Bernstein (1972) outline three kinds of "communicative sets" which can be considered as the binding rules in medical interviewing:

- **Primary system references**: This system stresses the necessity for a reciprocal relationship and the role played by the therapist [healthcare worker] and the patient in the enforcement of such a friendly relationship. A reciprocal or friendly relationship will ease tension on the part of the patient and consequently enhance effective communication.

- **Evaluative propositions**: This has to do with the general appraisal of statements of value by the doctor as the patient relates his/her illness. As the patient relates her/his symptoms, the points that are considered salient or vital in the diagnosis of

the illness should be acknowledged by a nod of the head or by a word of encouragement.

- **Affective propositions:** Here feelings or emotions are expressed by the patient, and the doctor has to be aware in order to dissociate them from the general explanation given by the patient about his/her illness.

These communicative sets, mentioned by Lennard and Berstein (1972), provide for effective communication in medical interviewing.

Sung (1998) carried out research on speech communication and found that ethnic diversity is a distinguishing characteristic in the United States of America (U.S.A.) and that the cultural backgrounds of patients have a significant impact on how diverse patients perceive their health and illness and deal with reality. According to Sung, there has been insufficient attention given to the cultural diversity of the patients in the studies of doctor-patient communication and patient satisfaction. Asian populations have been especially understudied compared to other ethnic groups such as white, black and Hispanics in the U.S.A.

The purpose of Sung's study was to provide an understanding of the Korean patients' world through the study of their relationship with medical systems and doctors in the

U.S.A. The dynamics between Korean patients and their cultures, how their culture as the repertoire of their meaning systems works when the patients try to understand their reality regarding medical experiences, was shown (Sung 1998).

Sung (1998) interviewed thirteen Korean patients (plus six patients for the pilot study) in Columbus, Ohio, and Korean doctors, nurses and interpreters for triangulation. The interviewing was conducted by an insider, who used the same language as the patients and shared and understood their traditions and beliefs. Sung found that, considering the diverse meaning systems within a culture, the best way to understand a culture is to be open to intra-cultural diversity, rather than trying to generalize or simplify a culture according to the group's ethnicity or race.

Jones and Yvette (1998) carried out research entitled *Patient noncompliance and the cardiovascular health of African-America elderly.* The purpose of the study was to examine the extent to which the Health Belief Model and the Reasoned Action Model could explain the occurrence of noncompliance with prescriptions by elderly African Americans and the effect of this noncompliance on cardiovascular health. More specifically, the study sought to ascertain how differences in socio-demographic variables (age, gender, socioeconomic status, education and income), social psychological variables (living arrangements) and intervening variables (knowledge about disease and prior contact with disease) can be predictive of the systematic variation of elderly African

American's noncompliance (lack of obedience) with their therapeutic regimen and resultant cardiovascular health. The study sample consisted of 140 subjects. A questionnaire designed to elicit information about perceived health status, compliance with therapeutic regimen and attitudes and behavioural practices was administered.

According to the two researchers, the results suggested that some of the socio-demographic factors had a positive impact on noncompliance. For example, educational attainment emerged as an important predictor of compliance. Although nearly half of the sample had a low educational attainment, most were compliant with their therapeutic regimen. Neither age nor income had a significant effect on noncompliance.

When related to perceptions of disease, the result showed that elderly African Americans who were cognizant of their predisposition to cardiovascular disease and who recognized the threat of certain health risk factors had a different attitude/belief perspective which affected their willingness to comply with their prescribed therapeutic regimen. Of all the normative factors examined in the study, doctor-patient communication, as well as education and counseling, emerged as the two normative factors which were significant predictors of noncompliance.

In summary, according to Jones and Yvette (1998), compliance (co-operation) is vital in medical communication. They held that if the 'communication cable' is severed, patients

could succumb to an interplay of poor communication and ultimate noncompliance. Failure to comply with the therapeutic regimen has the potential of increasing the elderly African American's susceptibility to more serious cardiovascular problems.

A study of the effects of the participation of cancer patients in teaching communication skills to medical undergraduates was carried out by Klein (1999). The aims of the study were to evaluate the immediate effects of the participation of patients with cancer on the attitudes and skills of undergraduate medical students undergoing an interview skills training programme, and to assess the effects of the participation of patients with cancer on the attitudes and interview performance of students two years later. Klein (1999) hypothesized that the participation of cancer patients would have specific beneficial effects on the attitudes and the interview performance of the medical students. The research showed that the ability to listen and the element of trust was considered an extremely important characteristic of hospital doctors.

In Hong Kong, Smith *et al.* (1999) carried out research on patient-centered communication. The objective was to identify the preferred approach in medical consultation. Participants, in their evaluation of the different pairs of doctor-patient interviews (each pair having one doctor-centered and one patient-centered interview), rated the patient-centered doctor significantly higher than the doctor-centered doctor. It was concluded from the findings that, when given the choice, Hong Kong patients would

strongly prefer patient-centered interviewing style, despite a health care system that is strongly doctor-centered.

Ellington *et al.* (1999) investigated the feminist approach to patient satisfaction in medical consultation. They were motivated by the fact that traditional health communication research has often ignored gender and has employed a quantitative biomedical perspective to predict behaviour. In the findings, patients viewed satisfaction as a negotiation process with physicians, in which themes of respect, caring and reassurance of expertise featured prominently. It was also apparent in the findings that patients' ways of knowing and preferences for feminist communication styles influenced perceptions of physician-patient communication satisfaction.

Of late, Africans (including South Africans), have developed an interest in doctor-patient communication-based problems. Ntonifor (1985) and Nyamboli (1993) are some of the researchers who have attempted an analysis of communication within the hospitals in Yaoundé, Cameroon. The researches were carried out in the central and northern provinces of Cameroon respectively.

Ntonifor (1985) and Nyamboli (1993), admitted the existence of certain problems in medical communication which stemmed from the following:

- Different cultural backgrounds of the doctors and the patients.

- Different religious backgrounds.
- Different social status.
- Language variations and
- Differences in terminology and attitudes.

As a consequence of the problems in medical consultation, (Ntonifor 1985 and Nyamboli 1993) suggested certain solutions which, if applied, may redress the situation. The solutions included the following:

- The doctors should be bilingual.
- Doctors should master peculiar slang or words of colloquial usage in the community within which they work.
- Pertinent aspects of the culture and psychology of the people should be learnt by the doctors and taken serious note of during consultation.

In South Africa, Howarth (1998) reported research conducted by a midwife at Kalafong Antenatal Clinic in Pretoria. The majority of the doctors there were from a different racial group to the patients and had different values. Patients were given photographs of different outfits and were asked to identify in which outfit they considered the doctor most trustworthy, competent and friendly and with which they would find it easiest to form a patient-doctor relationship. The patients were also asked how they preferred to be addressed by medical staff.

The results showed that 76% of patients said that they would prefer to be addressed by their first names and 19% preferred their first names, preceded by either "mama" or "sisi". Only six percent said they would want to be addressed by their surnames. Eighty-six percent of patients felt that doctors' clothing was important and 89% that doctors should wear name tags. For the female doctors, the patients preferred formal clothing, consisting of either a skirt, blouse or closed white coat or a shirt and a safari suit top. For male doctors, they preferred formal clothing, consisting of either long pants, shirt, a tie and closed white coat or long pants and a safari suit top (Howarth 1998).

Data collected in this study could be considered limited as respondents were compelled to choose only from the photographs presented to them. The tendency is also to go for the familiar (the white overcoat of the doctors). However, the issue of the patients expressing their opinions on how they wished to be addressed is quite relevant and appropriate, especially considering the cultural differences which are characteristic of many healthcare worker-patient interactions.

Ellis (1999) holds that many African cultures, like the Japanese, have an aversion to directness. Furthermore, some words (such as penis, rectum and vagina) are never verbalized in isiZulu. Thus a patient influenced by such a culture would find it difficult dealing with issues related to the above during consultation. This, according to Ellis, calls for a change in the approach of doctor- initiated interrogations.

2.4 Summary

In this Chapter, the literature pertaining to general considerations about communication-based problems, with a particular focus on the reference interview and those specific to the medical field, were discussed. Research done by different authors in the field of communication was highlighted. Many and varied opinions, as well as findings, were registered. Some included the fact that communication was affected by factors such as language, culture, gender, race and educational status, that may either nurture or obstruct the free flow of information. In cases where these factors obstructed the free flow of information, suggestions for amelioration were given, for example the use of trained interpreters, the importance of language in communication and the need for healthcare workers to learn the main language(s) of the community in which they are involved.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

Griesel, in her study of women literacy learners in a rural community, made mention of the fact that,

> If a researcher is working within a 'normal paradigm' of social science research, it is usually not necessary to make explicit the nature of the methodology to be employed. The research framework is generally accepted or understood, and all that is required of the researcher is to report on the method used in obtaining the results (in Leach 1991: 152).

The present study falls within a quantitative methodological framework is within a "normal paradigm". However, as mentioned by Polkinghorne (1983: IX), it is worthwhile understanding the "why" of one's design and the "how" of carrying it out. The purpose of this Chapter is to systematically describe the methodology of the present research, the tools and method of analysis used and the reasons for choosing them.

Leedy (1989: 88) defines methodology as an operational framework within which factors are placed so that their meanings may be seen more clearly. According to Bailey (1982: 33), methods do suggest certain methodological perspectives ranging from qualitative

(report of observations in natural languages with numbers seldom used) to quantitative (assigning numbers to observations).

Looking at the possible approaches to the problem under study, Trow holds that

> ...the most widely accepted view among social scientists is that different kinds of information about man and society are best gathered in different ways, and that the research problem under investigation properly dictates the methods of investigation (in Bulmer, 1977: 15).

Given the nature of the present study, the survey method (to be explained later) was adopted. Other aspects of the methodology were data collection procedure and technique and sampling method, including pretest and problems encountered. A review of them is given in this Chapter.

3.2 Data required

The data collected for this study was in response to the research questions:

- What are the key tangible verbal communication problems encountered by healthcare workers and patients during consultation?
- What are the key tangible nonverbal communication problems encountered by healthcare workers and patients during consultation?
- What are the key intangible communication problems encountered by healthcare workers and patients during consultation?
- What suggestions or recommendations based on the findings can be given?

3.3 Method and data collection technique

3.3.1 Research method

A survey method, as defined by Warwick & Lininger (1975: 1-2), is "a method of collecting information about a human population in which direct contact is made with the units of study ... through such systematic means as questionnaires and interview schedules". In deciding on the method of data collection, the main driving force was that a problem should determine the method to be used (Golden 1976: 9).

Mouton and Marais (1988: 42), refer to a "research goal" as that which "provides a broad indication of what researchers wish to attain in their research." They maintain that it is possible to distinguish among three main types of studies which incorporate aims that are exploratory, descriptive and explanatory. However Babbie (1979: 87) notes that although the given distinctions are useful, most studies will have elements of all. The present study, though not having elements of all, can be seen as both exploratory (exploring a comparatively unknown field) and descriptive (detailed description given of an individual, group or organization). Looking at the descriptive purpose of the study the survey method clearly applies. This is further clarified by Babbie's assertion that " Survey research is probably the best method available to the social scientist interested in collecting original data for the purpose of describing populations too large to observe directly... Surveys are also excellent vehicles for the measurement of attitudes and

orientations prevalent within a large population" (Babbie 1979: 316).

Criticisms have been made about the survey research method. Marsh (1982: 3) feels that the criticisms are "usually reactions to poorly designed, inadequately conceptualised and theorised, un-piloted or just ill-managed surveys..." De Vaus (1986: 220-225) concludes by saying that while surveys do have setbacks, "they are not as serious as many of the critics would have us believe."

3.3.2 Data collection technique

The data collection technique applied in the present study was a semi-structured interview (with the patients). This is defined by Stone (1984: 12), as one "in which some questions are structured ['closed'] and some are open-ended." For the healthcare workers, a questionnaire was used which they had to complete at their convenience and hand to the sister in charge for collection by the researcher.

Mouton and Marais (1988: 43) stated that in terms of the choice of a semi-structured interview and a questionnaire, one realizes that exploratory studies "frequently involve the use of in-depth interviews, the analysis of case studies, and the use of informants ". This meant that the survey method, based on semi-structured interviews and questionnaires, as used in the present study, appears to be incompatible with the exploratory purpose of the study. However, Golden (1976: 11) asserts that " while certain strategies may be more

suitable and more frequently used for certain purposes ... purpose does not necessarily dictate design". As an example, Golden makes mention of situations in which survey research has been used for exploratory purposes; thus the use of a semi-structured interview and a questionnaire.

As a point of caution with respect to the above techniques used in the collection of data, Busha and Harter (1980:78) stress that the interviewer must be well-prepared before the beginning of the questioning process. She/he should know not just the questions to be asked but also the sequence the questions will be posed in and the method by which the data will be effectively recorded. This is because "well-planned interviews and carefully worded questions usually produce the most useful information, as well as supplementary, insightful observations and opinions from respondents" (Busha and Harter 1980:78). In terms of questionnaires, Powell (1985: 90) cautions that they should be constructed in such a way that the quantitative data are collected and analyzed with relative ease. In relation to the manner in which they are distributed and responded to, an allowance should be made for them "to be completed, within limits, at the leisure of the participants". This, according to Powell (1985: 90), "encourages well thought out, accurate answers".

3.4 Sampling method

Sampling is considered by Powell (1985: 67) to be one of the most crucial steps in survey research. When doing research among black people in South Africa, Simon (1985: 115) recognizes the difficulty of attempting to construct an adequate sampling frame. Bulmer feels that a sampling frame with adequate coverage "is the exception rather than the rule." Taking the present study, the author was faced with a situation in which as emphasized by Rose (1982: 59), there was a working universe but it was not possible to construct a sampling frame. Rose suggested that, in such cases, "... Accidental, snowball, or judgement sampling may be used." Such sampling procedures are categorized as non-probability sampling methods which, according to Kalton (1983: 7), cover "a variety of procedures, including the use of volunteers and purposive choice of elements for the sample, on the grounds that they are 'representative' of the population." Purposive sampling, which is considered by Fraenkel and Wallen (1993) as judgmental, was the main method of this research. Burgess (1984: 55) says that "In judgment sampling, informants may be selected according to a number of criteria established by the researcher such as their status (age, gender and occupation) or previous experience that endows them with special knowledge." In selecting the sample of the present study, only black, isiZulu-speaking females were chosen. This was done because the vast majority of the patients were black, isiZulu-speaking females. A number of the questions required responses from someone who could speak for herself. For this reason, only female patients over the age of 18 were interviewed.

As mentioned in Chapter One, an average of 35 patients go to the Scottville Clinic on a consultation day. The consultation days are Tuesdays (for the general public), Thursdays (for the elderly) and Fridays (for the general public). All three days of consultation were targeted and 100 patients were interviewed within a period of three weeks. On average, 420 patients visit Scottsville Clinic in a month; some on a regular basis and others just once. Of the 420 patients, an estimate of 336 are black, isiZulu-speaking females. Given the time and financial constraints which prevented the interviewing of more patients, a sample of 100 was considered a reasonable size to work with.

Concerning the nurses, the Deputy Chief for Community Health in Pietermaritzburg was interviewed in relation to the number and race of the healthcare workers. She stated that Scottsville Clinic had five registered nurses (one being the sister in charge) and one enrolled nursing assistant. It also had two clerks. Looking at their different race groups, the majority (3) were whites, followed by Indians (2) and blacks (1). The two clerks who function as distributors of cards were made up of one Indian and one Black.

Consultations were done by the registered and enrolled nurses. It was observed that some student nurses came from time to time to assist in the consultations. The clerks were not included, as they were not involved in the consultation process. Five of the nurses and two student nurses, all involved in the consultation process, were subsequently contacted.

Looking at the disadvantages of non-probability sampling, Bailey (1982: 97) states that "the obvious disadvantage ... is that, since the probability that a person will be chosen is not known, the investigator generally cannot claim that his or her sample is representative of the larger population." This meant the lack of external validity that comes from findings that cannot be generalized to a broader population (Golden 1976: 15).

In view of the situation above, it is clear that the sample in this study had a major setback in the area of representativeness and consequently of external validity. However, as Phillips (1976: 295) states, external validity is also influenced by sample size, where the greater the sample size, the fewer the problems of internal validity. Phillip feels that a smaller sample, size which is the case in the present study, is likely to enable the investigator to concentrate more on internal validity (applying findings to the particular research situation under investigation).

3.5 Pretest

Fraenkel and Wallen (1993: 352) say that "A pretest of a questionnaire or interview schedule can reveal ambiguities, poorly worded questions, questions that are misunderstood, and unclear choices and can also indicate whether the instructions to the respondents are clear".

The pretest in this research was done by choosing three female healthcare workers and two female Zulu patients from the maternity section of Northdale Hospital. In addition, two female-speaking Zulu patients were interviewed from the Scottsville Clinic. The nurses were of a heterogeneous background, similar to those at the Scottsville Clinic (Indians, whites and blacks). The maternity section of the Northdale Hospital was chosen for the pretesting partly because it had similar patients to those at Scottsville (many of the female patients who visit Scottsville Clinic do so for gynecological reasons). Only black, female, isiZulu-speaking patients over the age of 18 formed the pretest group, given the focus of the study on such patients. The pretest was conducted immediately after the consultation process, with a view to identifying any obstacle in the procedure.

The following weaknesses were noticed during the pretesting:

- With respect to validity and reliability of data, which, according to Terre Blanche and Durrheim (1999), are composed of accuracy and consistency, the present author noticed some inadequacies. For example, all three patients were reluctant to express their views, especially those concerning the healthcare workers. It can be argued that such reluctance was due to perceived fear of maltreatment or bias by the healthcare workers, should the information come to their notice. This was particularly apparent with the questions relating to language and the attitude of the nurses. In view of this, it was decided that the patients would be interviewed out of sight of the healthcare workers and proper explanation given concerning the

purpose of the research and the confidentiality of it.

- It was noticed that the patients felt freer expressing their views of previous consultations. It was thus decided that a question relating to the previous consultation (irrespective of the health unit) of the patient would be included in the interview schedule.
- Finally, it was apparent from the pretest that the researcher had to exercise care and patience when interviewing the patients. This was due to the fact that during the pretest some of the patients were in pain and had to explain and show the areas where they were feeling the pain and even ask why the pain persisted after consultation.

The respondents were asked to comment on the clarity, language level and appropriateness of the questions asked. They were no problems in this regard. However, the nurses raised the issue of time, saying that they are often too busy to attend to interviews.

3.6 Procedure of data collection

Permission to conduct the study was obtained from the nurse in charge and the Health Department. This was done by means of a letter from the University (specifically from the Information Studies Programme) and a draft of the proposal, clearly stating the purpose and method of the research, as well as the interview questions. Measures were taken to

ensure anonymity. For example, no names were required from the respondents. The purpose of the research was clearly explained verbally and in writing (see Appendices A and B). Two female assistants who were isiZulu-first language speakers were employed to assist in the interviews. They had to assist in interviewing the patients who were unable to communicate adequately in English. During the interviews the researcher was present and wrote down the responses in English, as interpreted by the assistants. The interview process was facilitated by the fact that the interview questions had been pre-translated into isiZulu (see Appendix C). The assistants were trained by the researcher and were given a stipend. The patient interview was conducted immediately after the consultation process. This was to avoid memory lapse which might have occurred if patients had been contacted before the consultation or long after it. However, few questions related to remarkable incidences of previous consultations were as well asked. Taking into consideration the willingness of the patients to be interviewed, a highly positive response was registered. A majority of the patients were quite willing to be interviewed and those who were not gave valid reasons, such as time constraints, as they had to hurry back to their offices.

In the case of the healthcare workers, the questionnaires were given to them via the sister in charge. The healthcare workers had to complete them at their convenience and hand them to the sister in charge for collection.

3.6.1 Problems encountered

Certain problems were encountered during the collection of the data. These were:

- Poor communication within the health service in general. This was really a matter of concern as one had to deal with different people at different times and had to explain the same story over and over again.
- The healthcare workers were very busy during working hours and by the end of the day they were too exhausted to attend to interviews. As a consequence, the tea periods were targeted for interviews, which also was not feasible. The only other option was to resort to questionnaires. The questionnaires were administered personally via the sister in charge. The healthcare workers had to fill them in at their convenience and hand them to the same sister in charge for collection.

3.7 Data analysis

Analysis of the data in the present study was done manually and by computer using the Statistical Package for Social Sciences (SPSS). Data relating to the open-ended responses were done manually using content analysis which, according to Saunders and Pinhey (1983: 185), is a method of analyzing qualitative data. This method entails a systematic quantitative description of the composition of the object of the study (Gay 1976:137). Gay draws a distinction between simple and complex content analysis. The former (the one used in this study), involves frequency counts and the latter is used to investigate bias. With the closed questions, the analysis of the data was done by computer. Numerical

codes were assigned to the different categories and loaded into the computer. Finally, where appropriate, figures and tables were used to present the results of the findings (for both open and closed questions).

3.8 Summary

In this Chapter the various aspects related to the research methodology employed in the study were discussed. The method and data collection techniques used, namely the survey and semi-structured interview and self-administered questionnaire, respectively, were described. This was followed by a discussion of the sampling method used, namely a non-probability sampling method. The pretesting of the research instruments was described and this was followed by a description of the problems encountered during the data collection and the method of analysis of the data.

CHAPTER FOUR

RESULTS

This chapter presents the results of the study. Those results pertaining to the patients are listed first, followed by those of the healthcare workers. Where appropriate, the results are provided in Figures and Tables.

4.1. PATIENTS' RESPONSES

One hundred patients were interviewed as targeted, giving a response rate of 100%. To have a better understanding of the group of patients who participated, demographic-type questions were asked with respect to age, occupation and level of education. All the patients interviewed were black, isiZulu-speaking females, aged 18 and above. This category made up the vast majority of patients who visit the Scottsville Clinic. The results are presented in the Figures and Tables below:

4.1.1. Socio-demographic factors

4.1.1.1 Age of respondents

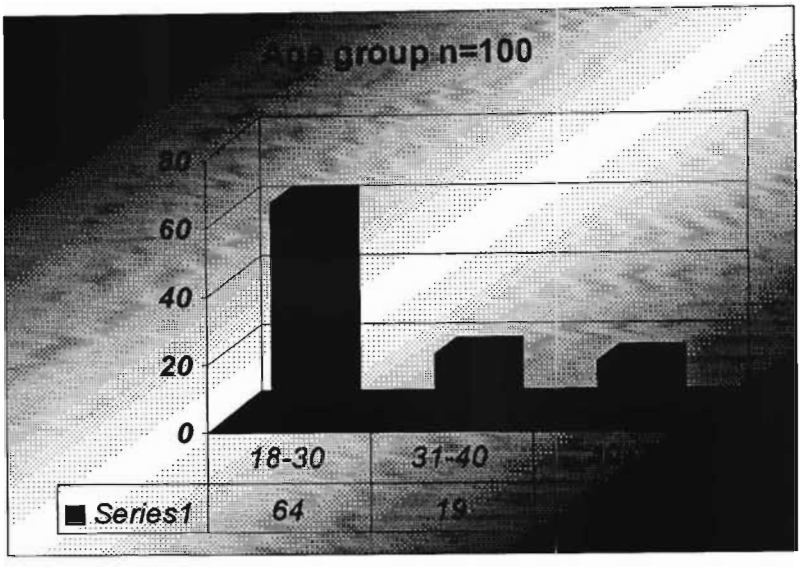

Figure 2. Respondents by age

Figure 2 shows that the vast majority of respondents (64%) fall within the 18-30 age group.

4.1.1.2 Employment level and job categories of employees

Just under half (48%) of respondents were employed. Of the 48 who were employed, the majority were domestic workers 39 (81%), followed by university lecturers and restaurant employees five(10%). The remaining four (8%), consisted of a field worker, a cashier, a mail distributor and a gardener.

4.1.1.3 Language of communication

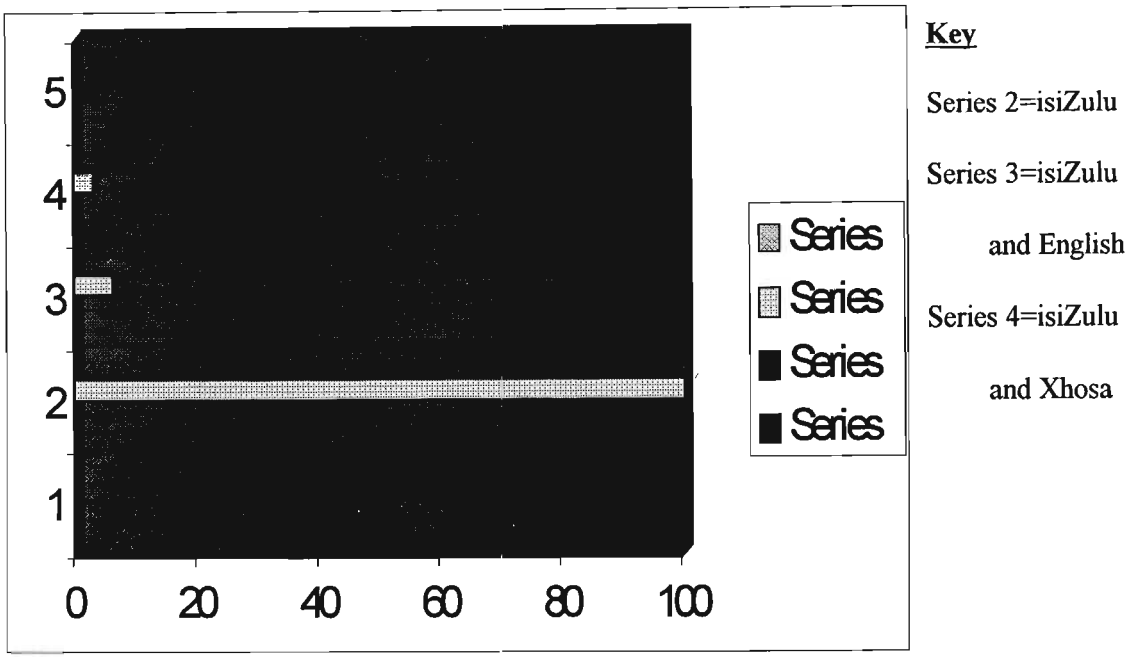

Figure 3. Respondents by language of communication

*Multiple responses given (Total = 109)

Figure 3 shows that of the 100 respondents, all (series 2) were able to communicate effectively in isiZulu. Of those, 6% (series 3) could also communicate effectively in English and 3% (series 4) in Xhosa.

4.1.1.4 Respondents by school attendance

Ninety-one respondents had attended school. Of these, the majority 51 (56%) had an educational level of standard one to standard nine. This was followed by Matric holders

27 (29%), undergraduates seven (8%), postgraduates four (4%) and diploma holders two (2%).

4.1.2. Factors that can possibly have an effect on communication

The tables below contain the results of factors that can have an effect on medical consultation as perceived by patients.

4.1.2.1. Age of healthcare worker

Table 1. Age of the healthcare worker as a factor in communication

Age a factor	n=100	Reason why it matters
No	71	
Yes	29	Twenty-three (79%) prefer older nurses. Of the 23, 13 (56%) feel older nurses are more experienced and knowledgeable, five (22%)) that older nurses are more caring, three (13%) that they are more patient and two (9%) that they are more mature and can explain and understand better than younger nurses. Three (10%) feel freer with someone of the same age grouping as they. Two (7%) prefer younger nurses especially when dealing with sensitive issues such as sex; the reason being that culturally, they do not discuss such things freely with the elderly. One (4%) feels that older nurses, though more knowledgeable and caring, sometimes assume that they know too much (would want to insist on their own point of view and would not give the patient a chance) and some of them are slow at acting.

The majority (71%) of the patients as illustrated above, did not consider the age of the healthcare workers as a problem in medical consultation.

4.1.2.2 Race of healthcare worker

Table 2. Race of the healthcare worker as a factor in communication

Race a factor	n=100	Reason why it matters
No	77	
Yes	23	Thirteen (57%) feel that some black nurses tend to be proud, cheeky, rude and un co-operative because they feel they are of the same race. Ten (43%) in order to communicate more easily and to understand one another better especially as cultures differ.

As seen from Table 2, a majority (77%) of the patients did not consider the race of the healthcare workers as an impediment in medical consultation.

4.1.2.3 Gender grouping of the healthcare worker

Table 3. Gender grouping of the healthcare worker as a factor in communication

Gender a factor	n=100	Reason why it matters
No	48	
Yes	52	Forty-nine (94%) feel freer and can speak more fluently and confidently with someone of the same gender grouping. Of the 49, two (4%) feel that they are not afraid of such nurses and four (8%) that they feel their problems are better understood by nurses of the same gender grouping as themselves. Three (6%) some females nurses are very rude and unsympathetic.

As indicated above, gender was seen as an issue to be reckoned with in medical consultation by 52% of the patients.

4.1.2.4 Language of the healthcare worker

Table 4. Language of the healthcare worker as a factor in communication

Group	n=100	Reason why it matters
No	5	
Yes	95	Seventy (74%) hold that language matters due to the fact that one can communicate and understand one another better when fluent in the same language and versed in the same cultural issues. Fourteen (15%) gave as an example of a language barrier the fact that they are not fluent in English. Most of the healthcare workers are and the latter, in an attempt to speak isiZulu, speak broken isiZulu "Fanakalo", which not only has deviations but sounds provocative. Seven (7%) hold that accent and terminology can be a problem, especially when one is not fluent in a particular language and has to use it for communication purposes. Three (3%) said that one can respond more easily in the language she/he is versed in and will feel freer in explaining her/his problem, especially when uneducated. One (1%) said that the healthcare worker can understand exactly what the problem of the patient is.

A vast majority (95%) of the patients acknowledged the fact that language mattered in medical consultation.

4.1.3. Issues directly related to consultation just completed at Scottsville Clinic

Below are results of what transpired during the consultation process as recounted by patients when interviewed immediately after the consultation.

Ninety-eight of the patients interviewed described their illnesses personally to a

healthcare worker without the use of an interpreter. Only two made use of interpreters. The following Tables therefore reflect the responses only of those who described their illnesses personally, namely 98.

4.1.3.1 Language used by respondent in illness description

Table 5. Language used in describing illness

Category	n=98	Percentage
isiZulu	29	30
English	69	70
Total	98	100

Table 5 shows that the majority of the respondents (70%) used English in describing their illnesses to the healthcare workers.

4.1.3.2 Understanding of respondent

Table 6. Understanding of respondent by healthcare worker

Understood	n=98	%	Reason
Yes	80	82	
No	18	18	Because of language differences.

4.1.3.3 Understanding of healthcare worker

Eighty respondents said when they explained their health problems to the healthcare worker, they were understood. Eighteen respondents, on the other hand, said they were not understood due to language differences. When asked if they on the other hand understood the healthcare worker, they responded thus:

Table 7. Understanding of healthcare worker by respondent

Understood	n=98	%	Reason
Yes	65	66	
No	33	34	Fifteen (45%) did not understand some of the medical terms. Fourteen (42%) had difficulties in understanding the broken isiZulu "Fanakalo". Four (12%) said in an attempt to communicate in isiZulu, the healthcare worker used English words that could not be translated into isiZulu.

4.1.3.4 Eye contact during consultation

In terms of eye contact maintained by the healthcare worker, as perceived by the patients, 90 (91%) said the healthcare worker maintained eye contact during the consultation. Eight (8%) said the healthcare worker did not look into their eyes when talking to them. Whether the respondents considered maintaining eye contact polite or not, and the reason for such considerations, are given in Table 8.

4.1.3.4.1 Perception and reason for eye contact

Table 8. Perception in relation to eye contact and reason for such perception

Eye contact	n=90	%	Reason
Polite	87	97	All 87 (100%) felt the healthcare worker was paying attention to what they were saying. In addition to that, 53 (61%) of the 87 were confident that they were better heard and understood; nine (10%) that the healthcare was concerned about their situation; five (6%) that it built a rapport between them; three (3%) that it depicted a welcoming attitude; two (2%) that it gave the assurance the healthcare worker was neither lying nor hiding anything; one (1%) that the healthcare worker was confident in what she was saying and one (1%) that due to the fact that some patients lie and hide information, she felt such contact would help avoid that. In all, there was the general consensus that the white culture gives room for eye contact, which is the reverse of the Zulu culture, but that given the advantages in it and the fact that things have changed and now there is a cross-cultural South Africa, they have come to accept it as well.
Not polite	3	3	One (33%) said because she had an eye problem. One (33%) said it is not part of her culture. One (33%) complained of feeling shy

4.1.3.4.2 Perception and reason for no eye contact

As mentioned, eight respondents noted that the healthcare worker did not look into their eyes. Whether that was considered polite or not and the reason for this is reflected in Table 9.

Table 9. Perception in relation to no eye contact and reason for such perception

No eye contact	n=8	%	Reason
Polite	0	0	-
Not polite	6	75	Showed she was not paying attention
Does not matter	2	25	-

4.1.3.5 Sitting position of healthcare worker during consultation

Respondents were asked what the sitting positions of the healthcare workers were during the consultation. Their responses are reflected in Table 10.

Table 10. Sitting position of healthcare worker and perception of it

Sitting position	n=98	Percentage	Perception
Leaned towards you	6	6	Four (67%) felt it did not matter Two (33%) felt it was polite
Leaned backwards	1	1	Felt it did not matter
Sat straight up	81	83	All felt it was polite
Stood	10	10	Considered it not polite

4.1.3.6 Healthcare worker's reaction to patient's situation

With respect to the reaction of the healthcare workers concerning the situation of the patients during the consultation, the respondents were asked to give their perception of it and the reason for such perception. Their responses are presented in Table 11.

Table 11. Reaction of healthcare worker to patient's situation and reason for patient saying so

Reaction	n=98	%	Reason
Showed concern	90	92	Twenty two (24%) she listened patiently to me expressing myself; 17 (19%) she asked questions in order to understand better; 13 (14%) she counseled me; 11 (12%) she was calm; six (7%) she gave good explanations; five (6%) she allowed me to express myself; four (4%) we could discuss freely; three (3%) she asked at the end if I was satisfied; two (2%) we talked a bit on other things; two (2%) she cracked jokes; two (2%) she used words such as 'shame' that depict sympathy; one (1%) she touched me and said 'hello'; one (1%) she took me as her sister and one (1%) she touched me when she noticed I was not paying attention.
Indifferent	8	9	Five (63%) she was in a hurry; one (13%) she did not ask me any questions; one (13%) she was not willing to get my own side of the story and was insisting on certain things that were contrary to what the former doctor told me; one (13%) she exclaimed and held her head when I explained my situation.

4.1.3.7 Look of healthcare worker during consultation

Respondents were asked to comment on the look of the healthcare worker during the consultation and to give a reason for making such comment(s).

The results are reflected in Table 12.

Table 12. Look of healthcare worker during consultation as perceived by patient and reason for such perception

Look	n=98	%	Reason
Friendly	89	91	She had a cheerful face (put on a smile).
Not friendly	9	9	All nine (100%) said she had an uninviting appearance (did not smile). In addition, seven said she was in a hurry and one said that you could tell the friendly look she displayed was mainly in fulfilment of the requirements of her profession and not out of sincerity of heart.

4.1.3.8 Body gesture of healthcare worker during consultation

Taking into consideration the body gestures displayed by the healthcare worker, 85 (87%) of the patients said that the former were sitting still besides writing; two (2%) that they were tapping their pens; one (1%) that the healthcare worker was looking around and 10 (10%) that they were standing. How the patients considered that and the reason for such consideration is shown in Table 13.

Table 13. How patients consider the body gestures of the healthcare workers and reasons for such consideration

Sitting still			
Response	**n=98**	**%**	**Reason**
Polite	85	100	Forty (47%) said it shows paying of attention; 25 (29%) interest and co-operation; 10 (12%) seriousness; six (7%) friendliness; two (2%) care and two (2%) full participation (that she is with me and not somewhere else).
Tapping the pen			
Does not matter	1	50	-
Not polite	1	50	Displays lack of concentration
Looking around			
Not polite	1	100	Shows lack of interest (nonchalant attitude).
Standing			
Not polite	10	100	Seven (70%) said it shows she was in a hurry and one added that especially as while standing she was doing something else; three (30%) that it shows lack of seriousness and commitment and one of the three gave as an example the fact that she had to strain her eyes and head looking up, as she was sitting down.

4.1.3.9 Manner of speech of healthcare worker during consultation

Taking into consideration the manner of speech of the healthcare workers, the respondents were asked how they perceived it and the reason for such perception. The results are presented in Table 14.

Table 14. Manner of speech of healthcare worker as perceived by patients and reason for such perception

Manner of speech	n=98	%	Reason
Polite	91	93	All 91(100%) said the healthcare worker spoke to them softly and that she did not shout at them. In addition to that, one (1%) said even when she did shout, you could deduce it was for her to hear better (spoke loudly but nicely); five(5%) that she cracked jokes; one (1%) that there was no argument and that she used inviting phrases such as "good girl" and one (1%) that she said things that made her happy to the extent of forgetting, for a while, the pains she had. Also that she talked to her as if they had known one another for some time.
Not polite	7	7	All seven (100%) said the healthcare worker was in a hurry. In addition, two (29%) said she spoke harshly (shouted at them).

4.1.3.10 Respondent's satisfaction of the consultation process

All respondents (including those who communicated via an interpreter) were asked if they were satisfied with the consultation. For those who said they were not satisfied, they were asked to give reasons for the dissatisfaction.

Table 15. Satisfaction with consultation and reason why patients were not satisfied

Satisfied	n=100	Reason
Yes	92	-
No	8	Each of the eight gave a different reason: Because I did not get a cough mixture; I wanted an injection but was not given and I know injections heal faster; the nurse just listened to me and did not ask any questions; she was very fast because she was in a hurry; she gave me just one tablet and there were interruptions from other nurses; was harsh to me; displayed an element of lack of confidence in what she prescribed (said she was not sure of what she prescribed).

The final question relating to the consultation just completed was whether respondents had any recommendations to make. Ninety of the patients gave one or more recommendations with regards to the consultation they had just completed at the Scottsville Clinic.

4.1.3.11 Recommendations with regard to consultation just completed at the Scottsville Clinic

- Of the 90 patients, 60 (67%) commended the healthcare workers for their caring, welcoming and receptive attitude and encouraged them to continue in that same spirit;
- Fifteen(17%) recommended that the Clinic be opened on a daily basis and that more staff be employed, given the shortage, whereby some patients come very early and have to stand outside for a while though sick;

- Two (2%) recommended that the healthcare workers be kind and have respect for others and avoid shouting at patients, regardless of their ages.

The remaining respondents (13) each made a different recommendation, stating that the healthcare workers should:

- avoid prejudging the patients and make sure they are well understood. If they are not understood, something should be done to redress the situation.
- get to know the culture of the patients in order to understand why they manifest certain characteristic traits.
- show perseverance with the patients, especially as some of them are very talkative.
- endeavour to calm down patients by explaining to them why they have to wait for long before consultation.
- be confident in what they say, especially the trainee nurses.
- work during tea time, as patients who have been waiting for their turn, have to wait during tea time.
- show genuine politeness, because sometimes it is not sincere.
- avoid coming to work with personal problems.
- sit down when talking to patients and avoid being in a hurry or displaying signs of it, even if they are about to close.
- be mindful of interruptions, as they disturb the consultation.
- show more consideration to patients who are very sick.
- be willing to get more advice on how to behave towards patients and not feel they

know it all.

- endeavour to ask questions, as that also depicts interest.

4.1.4 Experience from previous consultations (not necessarily from the Scottsville Clinic)

Seventy (70%) of the respondents gave one or more problems encountered in previous consultations irrespective of the clinic, 25 (25%) had no problems, which meant that all went well and five (5%) had nothing to say as, it was their first consultation.

- Out of the 70 respondents who encountered problems, 61 (87%) cited cases of rudeness, pride, cheekiness, lack of care, impoliteness, especially in asking and answering the questions posed by patients and the healthcare worker not wanting to listen to them. As examples of such cases, one white, four Indians and 56 black healthcare workers were cited.
- Six mentioned having to wait for hours before consultation.

The remaining three made the following observations:

- not much time is given for the consultation due to staff shortage.
- some nurses spend time chatting instead of doing their work.
- differences in language, whereby some of the nurses could not speak isiZulu and those who attempted to spoke broken isiZulu or "Fanakalo".

4.1.5. Cultural and other related issues

4.1.5.1 Things not openly talked about and examples of such things

In terms of things not openly talked about, 70 respondents acknowledged such cases while 30 claimed they were not aware of any. Those who acknowledged that there were such cases gave as examples issues relating to sex, especially between parents and children (the old and the young) and family matters, as these two categories are meant to be highly confidential. The example was given of the rape of a child by one of the parents. One of the respondents refused to give examples, saying that she could not talk about them even to the researcher.

4.1.5.2 Preferential treatment of patients

The final question asked of respondents was whether healthcare workers treat patients differently from each other and their reasons for saying so. The results are given in Table 16.

Table 16. If healthcare workers treat patients differently and reasons for saying so

Responses	n=100	Reason
Yes	50	Thirty-five (70%) said you can see they judge you from your looks, colour, educational and social status, before giving you the respect you deserve. Fifteen (30%) said that the healthcare workers tend to be impatient with the poor and they pay more attention to those close to them (friends and family members).
No	50	-

Looking at the above result, 50% of the patients admitted the fact that healthcare workers treat patients differently for various reasons such as looks, race, educational and social status.

4.2. HEALTHCARE WORKERS' RESPONSES

The majority of the healthcare workers at the Scottsville Clinic are whites (3), followed by Indians (2) and a single black. With the exception of one Indian nurse, all the healthcare workers completed the questionnaire. In addition, two Indian student nurses were included in the study. Four of the healthcare workers were between 31 and 40 years old and the fifth was over 40 years of age. Both student nurses were between the ages of 19 and 30. On average, these healthcare workers indicated putting in seven to nine hours per day at work and attending to approximately 31-40 patients. All could effectively communicate in English, one (black) in isiZulu (not "Fanakalo") and two (whites) in Afrikaans.

As with the patients, the healthcare workers were asked to comment on the factors which could have an effect on communication. The responses are provided in the Tables below.

4.2.1. Factors that can possibly have an effect on communication

4.2.1.1 Level of education a factor in communication

Table 17. Educational level of the patient as a factor in communication

Education a factor	n=7	Reason why it matters
No	5	
Yes	2	One respondent said it was because some clients needed more detailed information and counselling than others. The other respondent said that it is a problem in terms of knowing if the patient is ill. For example, some uneducated patients do not know that discharge is an indication of a disease.

4.2.1.2 Gender grouping of patient

Table 18. Gender grouping of the patient as a factor in communication

Gender a factor	n=7	Reason as to why it matters
No	2	
Yes	5	All respondents said some patients feel shy and do not disclose certain information to healthcare workers of the opposite gender grouping. Sexually transmitted diseases are an example of this.

4.2.1.3 Language of patient

Table 19. Language of the patient as a factor in communication

Language a factor	n=7	Reason as to why it matters
No	-	-
Yes	7	All seven respondents said the client can have a full knowledge and understanding of her/his situation if the appropriate language is used. This leads to client satisfaction.

The healthcare workers were asked to give examples of language-related problems and to comment on how they respond to them.

4.2.1.4 Examples of language-related problems and how healthcare workers respond to them

As examples of language-related problems, all the healthcare workers said that patients sometimes do not understand the language they use. With respect to how they respond to such a problem, they all said they use interpreters, who could be a nurse, a patient or a relative. In addition, one respondent said she attempts to simplify instructions.

4.2.1.5 Culture of the patient as a factor in communication

When asked if the culture of the patient could be a problem in communication and, if so, how the healthcare workers deal with it, the following responses were given:

Four healthcare workers acknowledged the fact that the culture of the patients could be a problem in communication, pointing out that they have encountered instances of this. Two of the four said that not enough time is given to look into such problems, eventhough they are encountered frequently. The other two said that they counsel the patient regarding making a choice between her health and her culture. Of the two respondents who proposed this counselling method, one gave as an example the fact that you can tell a malnourished young bride to eat eggs and she will refuse because her culture does not permit it. The patient would then be counselled about making a choice between her health and her culture.

4.2.1.6 Time and work-load

On average, the healthcare workers indicated putting in seven to nine hours of work and attending to approximately 31-40 patients. When asked their impressions in relation to the hours put it and the work-load, they gave the following responses:

- Five said it is "pressurising" but that they can cope with the situation.
- Two said there is not enough time for good consultation to take place.

4.2.1.7 Information withheld by patients and examples of such information

In terms of information withheld by patients during consultation, six healthcare workers acknowledged such cases, while one claimed she was not aware of any. Those who acknowledged such cases gave as examples sexually transmissible diseases (three),

pregnancies (two), personal problems (one) and certain symptoms (one).

4.2.2 Recommendations relating to the consultation process

Four of the seven healthcare workers gave recommendations regarding improving the effectiveness of the consultation process. These recommendations are that:

- every patient be treated with respect and confidentiality (one).
- each patient be treated as an individual with specific needs and be given the correct information for her/him to then choose between her lifestyle and her health (one).

- staff should make an effort to speak the language of the patient and patients should also make an effort to understand the nurses (one).
- enough time should be ensured in order to have effective consultation (one).

4.2.3 Summary

In this Chapter the results of the study were presented. Those pertaining to the patients were listed first, followed by those to the healthcare workers. Where appropriate, the results were provided in Figures and Tables. One hundred patients were interviewed and in order to have a better understanding of the group of patients who participated, demographic-type questions were asked with respect to age, occupation and level of education. With respect to the healthcare workers, it was found out that the majority of them were whites (3), followed by Indians (2) and a single black. All of them could

effectively communicate in English, one (black) in isiZulu (not "Fanakalo") and two (whites) in Afrikaans.

CHAPTER FIVE

DISCUSSION OF RESULTS

5.1 Introduction

Discussion of the results of this study is based on the set objectives outlined in Chapter One. The objectives were:

- To establish the key tangible verbal communication problems encountered by healthcare workers and patients during consultation.
- To establish the key tangible nonverbal communication problems encountered by healthcare workers and patients during consultation.
- To establish the key intangible communication problems encountered by healthcare workers and patients during consultation.
- To make recommendations based on the findings.

In this Chapter, each of these objectives is discussed in relation to the results of the survey and the available literature.

5.2 Key tangible verbal communication problems encountered by healthcare workers and patients during consultation.

The key tangible verbal communication problems that this study sought to establish were voice tone/attitude and language.

5.2.1 Voice tone/attitude

Wyner (1927: 58) lists certain techniques which the librarian should adopt in the reference interview:

- never act or look annoyed or indifferent
- never look or seem too busy to be interrupted
- meet all comers more than half way
- seek out the floundering individual and offer help.

The above techniques have much bearing on the consultation process between a healthcare worker and a patient. As noted earlier, Mchombu (1992:29) points out that "Relevant content must be supported by appropriate presentation if information products are to have the desired impact. The content might be right but if the presentation is inappropriate then the communication process will not be successful".

In the present study, respondents were asked to comment on the manner of speech of the healthcare worker. As seen in the results (Table 14), 91 said the healthcare workers were polite to them, the reason being that they spoke to them softly and did not shout at them. In addition to that, one respondent said that even when the healthcare worker did shout, you could deduce it was for her (the respondent) to hear better "she spoke loudly but nicely"; five respondents said that the healthcare worker cracked jokes; one stated that there was no argument and that she used inviting phrases such as "good girl". A further

respondent said that the healthcare worker said things that made her happy, to the extent of forgetting her pains for a while, and that she talked to her as if they had known one another for some time. These positive responses to the healthcare workers confirm Green's stated qualities of a reference librarian (healthcare worker), namely "a courteous disposition, sympathy, cheerfulness, patience and enthusiasm ." Other qualities were that the librarian (healthcare worker) should "mingle freely with the users and help them in every way to gain respect and confidence ...[that] they find [her/him] easy to get at and pleasant to talk with"(Green 1976: 78). It also confirms Bacon's view of a reference librarian (healthcare worker), of being "approachable, tactful (and)...possessing a sense of humor" (Bacon 1902: 929). Finally, it illustrates the fact that a communication process should go beyond the normal exchange of information. Grogan (1991: 89) stated that it must not just be a transfer of information but a social act involving a human face (human bond).

In order to get more information concerning the voice tone/attitude of the healthcare worker, questions were asked about the reaction of the healthcare worker to the patient's situation, the patient's satisfaction with the consultation just completed, and the patient's experience from previous consultations. Their opinion on whether healthcare workers treat patients differently (not necessarily at the Scottsville Clinic) was also sought. Table 11, shows that the majority of patients 90 (92%) said the healthcare workers showed concern about their situation, the main reason being that the healthcare workers listened

with perseverance to them expressing themselves. Jennerich & Jennerich (1997) commend such quality of a librarian (healthcare worker). They said it is necessary for a librarian (healthcare worker) to listen in order assess the situation. The results show that listening is an aspect of politeness and that the healthcare workers are concerned about the well-being of the patients.

However, it was noticed that while the immediate consultation was, on the whole, viewed positively, it was not the case when respondents referred to previous consultations (irrespective of the Clinic). The reason as earlier inferred, being that of perceived fear of maltreatment or bias by the healthcare workers, in spite the necessary precautions taken by the researcher. This was particularly apparent with the questions relating to language and the attitude of the nurses. Out of the 70 (70%) patients who encountered problems, 61 (87%) cited cases of rudeness, pride, cheekiness, lack of care and impoliteness, especially in asking and answering questions posed by patients. As examples of such cases, one white, four Indians and 56 black healthcare workers were cited. Jennerich and Jennerich (1997) stress that the tone of the voice of the healthcare worker should be appropriate and that a librarian (healthcare worker) should sound concerned even when saying "I can see you are lost". This is to avoid any form of misconception by the user who might otherwise consider such remarks as provocative.

Looking at the discriminatory attitude of some healthcare workers (Table 16), 50 patients said healthcare workers treat patients differently from each other. Out of the 50, 35 (70%) gave as reasons for such allegation the fact that it is apparent that the healthcare workers judge by looks, colour and educational and social status. Fifteen (30%) said that the healthcare workers tend to be impatient with the poor and pay more attention to those close to them (family members and friends). From this result it can be suggested that judging a person's social status, level of sophistication or intelligence mainly on appearance may cause premature diagnosis which according to Jennerich Jennerich (1997), can lead to unproductive results. Wyner (1927) advises that the reference librarian (healthcare worker) should "meet the public as [she/he] will want to be met".

5.2.2 Language

It is stressed in the *Communication Handbook* (1983) an accepted code or language must be chosen in a communication process. The code needs to be known by both parties, enabling the information to flow freely, without ambiguities. For example, if the source (the healthcare worker) has to initiate a conversation or pass across a message to the receiver (the patient), she/he must use the appropriate code or language. If an isiZulu speaker is being addressed, then the appropriate language will be isiZulu. If an uneducated patient or a patient not versed in the medical jargon is being advised, then a simplified language (terminology broken down to the level or understanding of the patient) must be used. However, in the selection of the code, the source (healthcare

worker) is not to focus solely on the convenience of the receiver, but also on her/his convenience (being able to conveniently speak the language selected). This is because it is the convenience of the two parties that contribute to the free flow of information.

The importance of an appropriate code (language) is further emphasized by the present study as 95 respondents (Table 4) supported the fact that language does have an effect on the communication process. The main reason for this is that one can communicate and understand one another better when both are fluent in the same language and versed in the same cultural issues. An example of the issue of being versed in the same cultural issues is seen in the results of things not openly talked about. Seventy respondents cited cases of sex and family related matters as things they do not openly talk about in accordance with Zulu culture. This was confirmed by the healthcare workers, who quoted sex related problems as some of the information that patients withhold during a consultation process. This means that a healthcare worker versed in the culture of a patient will better understand why the patient is hesitant about discussing or disclosing certain information. The healthcare worker will then be in a better position to handle the situation.

Looking at the consultation process at the Scottsville Clinic, it is noticed from Table 6 & 7 that 80 (82%) of the respondents said that when they explained their illnesses to the healthcare worker they were well understood and 65 (66%) said that they understood the healthcare worker well. However, when these results are compared with those relating to

the languages the respondents are fluent in and those they used during consultation, a problem of language emerges. For example, all of the respondents (100) indicated that they could communicate effectively in isiZulu and only six indicated they could communicate effectively in English and three in Xhosa (Figure 3). When this is compared with the languages the healthcare workers are versed in, it portrays a degree of language difference, as all of the healthcare workers can effectively communicate, but in English and, only one (black) can effectively communicate in isiZulu (not "Fanakalo") and two (whites) in Afrikaans. When asked what languages they used in describing their illnesses, the majority (69) of respondents said English and the minority (29) said isiZulu (Table 5). This means that the majority of the patients describe their illnesses, but in a language in which they are not fluent, namely English. The minority described their illnesses in a language they are fluent in namely isiZulu.

A language problem is also seen from the fact that 18 (18%) complained of not having been well understood because of language differences (Table 6) and 33 (34%) of not having understood the healthcare worker well for various reasons. For example, 45% said it was due to the medical terms used, 42% because of difficulties in understanding the broken isiZulu ("Fanakalo") and 12% of respondents attributed their lack of understanding to the use of English words that could not be translated into isiZulu, by the healthcare worker in her attempt to communicate in isiZulu (see Table 7). A confirmation of this comes from the healthcare workers, who spoke of language related problems

during consultation. The way the problems were handled (use of interpreters), is another area of concern, as Katz (1989: 16) states that the message in a communication process should be clear and need no translating to be understood.

The problem of language as a whole, is examined by Low (1996: 146), who asserts that the role of public libraries (just as any other information providers, as in the medical setting) is to help people find the information they seek, regardless of their command or knowledge of the English language. Concerning the medical consultation in a cross-cultural setting, Ellis (1999:1) maintains that the healthcare worker should be able to convey messages that make sense to the patient and likewise receive from the patients messages that make sense. In this case, it is not just a question of language, but of metaphors, idioms, slang, euphemisms, circumlocutions and mumbling. Looking at the different language problems highlighted, the researcher tends to agree with Cicourel (1987:77), who states,

> the physician and linguist face similar problems; how to make visible, those aspects of discourse and textual materials that seem to be intended, implied or misleading...[that] the patient finds it difficult to follow the physician's [healthcare worker's] language and often tacit or even explicitly, specified symbolic recoding. The patient's literacy or rationality, even if he or she is highly educated, is no match for the physician's language and external memory system; a system that is in constant tuning if the doctor is able to keep up with new developments in medicine.

From the above results, most of the patients said they understood the healthcare worker very well and *vice versa*. The dominant language (English) used during consultation was that which most of them were not fluent in. As such, it can be inferred that patients sometimes assume understanding. With this in mind, one tends to agree not only with Cicourel's statement, but also with the allegation of Shuy (1979) that the importance of language is not adequately recognized in medicine.

5.3 To establish the key tangible nonverbal communication problems encountered by healthcare workers and patients during consultation

The tangible nonverbal components examined were eye contact/culture, gestures, body postures and facial expressions.

5.3.1 Eye contact/culture

Eye contact is considered by Jennerich and Jennerich (1997) to be a powerful tool in the reference (medical) interview. The two parties concerned should have eye to eye contact during the interview. However, cultures and individuals differ. The North American culture, for example, requires eye contact. Behrens (1990:93) gives an example of the Zulu culture in which eye contact is avoided as a sign of respect; a Zulu son, out of respect, would not gaze directly into his father's eyes for an extended time during communication. This refers to the fact that in an interview, there is the possibility of encountering users who out of respect for the elderly (as reflected in her/his culture), will

avoid eye contact. Nonetheless, Jennerich and Jennerich (1997) feel that, whatever the case, the librarian should attempt to maintain eye contact which to a greater extent, was observed at the Scottsville Clinic. From the results of the study, the majority 90 (91%) of the respondents felt that the healthcare workers maintained eye contact when communicating with them during the consultation (Table 8).

Dodd (1987) maintains that nonverbal communication is highly culture-specific and that, although different cultures could produce similar nonverbal behaviours, each culture could have entirely different meanings for the behavioural cues. This holds true with the findings of this study; one respondent considered eye contact not polite because it was not part of her culture, but most of the respondents 87 (97%) acknowledged that white culture encourages eye contact. This is the opposite of Zulu. However, even though it was found that eye contact is not part of Zulu culture, especially between the young and the old, the Zulus have come to accept it as they now live in a cross-cultural South Africa. Their acceptance of eye contact is also due to the advantages inherent in it. For example, of the 90 (91%) respondents who said the healthcare workers maintained eye contact, 87 of them acknowledged the fact that it was polite. The main reasons were that it showed the healthcare worker was paying attention to what they were saying and that it gave them the confidence that they were better heard and understood (Table 8).

5.3.2 Gestures and body postures

Jennerich & Jennerich (1997) assert that gestures should be curtailed in order to avoid distraction. This was found to be the case in the present study, as a majority (87%) of the patients (Table 13) said that the healthcare workers were sitting still (beside writing). Of these, 40 (47%) said that the fact that the healthcare worker was sitting still made them feel that the worker was paying attention.

A relaxed posture is preferable to a stiff, ill-at-ease appearance, especially on the part of the librarian (healthcare worker). Interest is built on the part of the user when there is a slight leaning toward her/him, as opposed to leaning back and crossing arms (Jennerich &Jennerich 1997). Jennerich & Jennerich prefer a slight leaning towards the user because they feel it builds interest, but the present study (Table 10) reveals that sitting straight up was referable, as a majority of the respondents 81 (83%) said it was polite for the healthcare worker to sit straight up. Nevertheless, of the six who said the healthcare worker leaned towards them, two said it was polite and four said that it did not matter (meaning they were not against it).

The present study also showed that posture should be appropriate to the environment and the circumstances concerned. Respondents (10%) said the healthcare worker stood up while talking to them and none considered this to be polite (Table 10). In Table 13, seven said it shows she was in a hurry and one added that while standing she was doing

something else, which aggravated the feeling that the healthcare worker was in a hurry.

5.3.3 Facial expressions

In the case of users manifesting certain disturbing traits such as getting restless and emotional, the librarian (healthcare worker) is expected to avoid reflecting anger and frustration and rather show empathy and sincerity (Jennerich & Jennerich 1997). A humorous remark made by the user should possibly be appreciated with a smile. Concern should be shown when the user is worried or sad. It is also seen that to be friendly (inviting), one needs to put on a genuine cheerful look. This is shown by the results in the present study, where a majority of the respondents (91%) considered the healthcare workers friendly by virtue of the fact that they put on cheerful looks (Table 12). Nine (9%) felt they were not friendly because they had an uninviting appearance, that is, they did not smile.

With regard to facial expression, one can conclude with the statement of Wyner (1927: 58), that in a reference interview (consultation), the reference librarian (healthcare worker) should "never act or look annoyed or indifferent [and] never look too busy to be interrupted." This is because such characteristics, are considered acts of impoliteness by the patients and they block the free flow of information.

5.4 To establish the key intangible communication problems (race, age, gender, education and culture) encountered by healthcare workers and patients during consultation

5.4.1 Race

The race of the healthcare worker was not seen as a major issue, because the majority of the respondents (77) did not consider it a factor that could have an effect on communication. However, it was seen from the 23 who did consider it a factor that they did so mainly in relation to the attitude of the healthcare workers. This is substantiated from the results shown in Table 2. More than half (13) of the 23 respondents preferred a healthcare worker of a different race, because they felt the black nurses were proud, cheeky, rude and uncooperative by virtue of the fact that they were of the same race. This same issue was raised with respect to patient's experience from previous consultations; out of the 70 respondents who encountered problems, 61 (87%) cited cases of rudeness and cheekiness and, as an example, 56 of such cases were identified as coming from the black nurses. Ten of the 23 respondents above acknowledged the importance of race by virtue of the fact that communication can take place more easily between persons of the same race.

From the preceding discussion, it can be concluded that besides the ease in communication with a healthcare worker of the same race, patients would prefer a polite and co-operative healthcare worker of a different race to an impolite and uncooperative

healthcare worker of the same race.

5.4.2 Age

According to the majority of respondents (71), the age of the healthcare worker was not considered a factor that could have an effect on communication. Those who did consider it a factor (29), did so on grounds of preferences which are pointers to what is expected of the healthcare workers, irrespective of their ages. For example, as seen in (Table 1), some 13 (56%) preferred older healthcare workers because they felt they are more experienced and knowledgeable and five (22%) because they are more caring. Three (10%) preferred someone of the same age because they feel freer with them and two (7%) preferred younger nurses, especially when dealing with sensitive issues such as sex. The reason was that culturally they do not discuss such sensitive issues.

5.4.3 Gender

In terms of the results of the study indicated in Table 3, the gender of the healthcare worker is a major factor in communication. A small majority of the respondents (52) indicated that gender is important in communication. The reason given by the vast majority (49) of the 52 respondents is that they feel freer and can speak more fluently and confidently with someone of the same gender grouping, are not afraid and feel their problems are better understood by nurses of the same gender grouping. However, three (6%) of respondents indicated that some females nurses are very rude and unsympathetic.

When one considers the responses of the healthcare workers, the question of gender in the communication process is clearly an important one. Out of the seven healthcare workers that responded, five saw gender as a factor that can have an influence on communication. They gave as reasons the fact that some patients feel shy and do not disclose certain information, such as that concerning sexually transmitted diseases, to healthcare workers of the opposite gender grouping.

5.4.4 Education

Taking into consideration the responses of the healthcare workers, one would say that the educational level of the patients does not count much as a factor in communication. This is because only two of the seven respondents indicated that the educational level of the patients can be a factor in communication (Table 17). However, when the educational level of the patient is seen in connection with language, it becomes a factor in communication. Language, can be seen as a system of symbols, words, sounds and gestures, used for the conveying of information, where the latter is conveyed through the effective understanding of the same language (isiZulu, English, Afrikaans and others, including appropriate body gestures) and through familiarity with the language of the profession in place (medical language). Putting the two (education and language) within the context of a multi-lingual society such as South Africa's, people can be literate in the vernacular such as isiZulu but will have limitations in coping with life's demands. For example, in KwaZulu-Natal, a fair level of basic literacy in the English language is

required (literacy in the sense that a person who is able to read and write a particular language, such as English, is likely to be able to speak it). In this light, it becomes apparent that the educational level of the patient should be given due consideration. Drawing an example from the sample population once more, all the patients could effectively communicate in isiZulu (Figure 3) and only six could effectively communicate in English, which is the main language of communication in a medical setting such as the Scottsville Clinic. In addition to the problem of education in connection with language, the two healthcare workers (Table 17) who saw education as a factor in communication gave as reasons the fact that some clients need more detailed information and counselling than others. Also that some uneducated clients do not know that certain symptoms are indicative of diseases, for example, a "discharge".

5.4.5 Culture of the patient as a factor in communication

Four healthcare workers acknowledged the fact that culture can be a problem in communication as they have encountered instances of this. As to how they deal with it, two said that not enough time is given to looking into such problems even though they are encountered frequently. The other two said that they counsel the patient for her to then make a choice between her culture and her health. Of the two who proposed the counselling method, one gave as an example the fact that a healthcare worker can tell a malnourished young bride to eat eggs but she would refuse because her culture does not permit it. The patient would then be counselled in terms of her making a choice between

her health and her culture.

However, when culture is examined in connection with other socio-demographic factors such as the age and race of the healthcare worker, it is noticed that it does not carry much weight even though it does have an effect on communication. For example, a majority (70) of the patients said there are things that they do not openly talk about (with respect to their culture). They gave as an example the discussion of sex, particularly between parents and children. From this example, one would have expected more of the patients to prefer healthcare workers who are of same age group and culture. Instead, the majority of the respondents (71) did not consider the age of the healthcare worker an issue. Of the (29) who did, the majority (23) gave preference to the older healthcare workers by virtue of their experience, care and patience (Table1).

In terms of race, the majority of the respondents (77) did not consider the race of the healthcare worker an issue and of the (23) who did, more importance was given to attitude than to culture. For example, 13 (57%) of the 23 said they prefer a healthcare worker of a different race because those of the same race tend to be proud and cheeky (Table 2).

Such findings reiterate the earlier point that, if patients are to make a choice of who they will want to go to for consultation, the majority will prefer a healthcare worker of the

same gender grouping who is more experienced, caring, polite and patient, to the one who shares the same culture as themselves, but lacks such qualities. This does not dispute the fact that the "ideal" will be a healthcare worker who has both qualities (experience, patience, politeness and shares the same culture as the patient). This is because, in as much as more preference with respect to the age and race of the healthcare worker is given to attitude and experience (Table 1 and 2), the importance of culture is nonetheless acknowledged (Table 2).

Taking into consideration the above social demographic factors (race, age, gender, education and culture), which in this study are treated as intangible factors, Jones and Yvette (1998) sought to ascertain their influences on the consultation process. They wanted to know how their differences could be predictive of systematic variation of elderly African American's noncompliance (lack of obedience) with their therapeutic regimen and resultant cardiovascular health. According to the two researchers, the results suggested that some of the socio-demographic factors had a positive impact on noncompliance and educational attainment emerged as an important predictor of compliance. Although nearly half of the sample had a low educational attainment, most were compliant with their therapeutic regimen. Neither age nor income had a significant effect on noncompliance.

In the present study, it is seen that among the socio-demographic variables (age, race, gender, education and culture), the gender of the healthcare worker emerged as an important factor governing effective communication. This is because the majority of the respondents indicated feeling freer communicating with someone of the same gender grouping in a consultation. Taking into consideration the responses of the healthcare workers, one would say that the educational level of the patients (as is the case of Jones and Yvette's research) does not count much as a factor in communication in this study. This is because only two of the seven healthcare workers indicated that the educational level of the patients are a factor in communication. It is worth noting that education and language within the context of a multi-lingual society such as South Africa's are crucial to the demands of living especially in KwaZulu-Natal, where a fair level of basic literacy in the English language is required. The educational level of the patient therefore, also becomes an important factor in communication.

Drawing an example from the sample population once more, all the patients could effectively communicate in isiZulu (Figure 3) and only six, in addition to that, could effectively communicate in English, which is the main language of communication in a medical setting such as Scottsville. In addition to the problem of education in connection with language, the two healthcare workers (Table 17) who saw education as a possible factor in communication, gave as reasons the fact that, some clients need more detailed information and counselling than others and that it is a problem in terms of knowing if

someone is ill. For example, as earlier noted, some uneducated patients do not know that discharge is an indication of a disease.

Race and age of the healthcare worker were seen more in terms of experience and attitude (patience, care and politeness exercised by the healthcare) to culture (the former sharing the same culture with the latter). This does not dispute the fact that the "ideal" would have been a healthcare worker who has both qualities (experience, patience and politeness and sharing same culture as the patient). This is because, as the patients gave more preference to attitude and experience (Table 1 and 2), they nonetheless, acknowledged the importance of culture with the backing that they could communicate more easily and understand one another better (Table 2).

All in all, the over-riding factors of communication in the present study included voice tone/attitude, eye contact, sitting position, gestures, facial expression, gender and language. Culture mattered much when seen in terms of people being able to speak the same language and understand one another with respect to the contextual meaning of words.

Ntonifor (1985) and Nyamboli (1993), in similar research on doctor (healthcare worker) and patient communication within the hospitals in Yaoundé, Cameroon, noted similar factors as above with different sample populations. For example, their research

embodied both men and women of different age groups, while the present study involved just females of a particular ethnic and age group. They noted the existence of certain problems in medical communication which stemmed from the following:

- Different cultural backgrounds of the doctors and the patients
- Different social status
- Language variations
- Differences in terminology and attitudes.

As a consequence of the problems in medical consultation, Ntonifor (1985) and Nyamboli (1993) put forward certain solutions which, if applied, may redress the situation. The solutions included the following:

- The doctors should be bilingual
- Doctors should master peculiar slang or words of common usage in the community within which they work and,
- Pertinent aspects of the culture and psychology of the people should be learnt by the doctors and taken serious note of during consultation.

5.5 Recommendations with regard to consultation just completed at Scottsville Clinic

Recommendations were made by both patients and healthcare workers regarding improving the effectiveness of the consultation process. From the recommendations it was observed that the major area of concern was the attitude of the healthcare workers.

For example, of the 90 patients that made certain recommendations, 60 (67%) commended the healthcare workers for their caring, welcoming and receptive attitude and encouraged them to continue in that same spirit. The healthcare workers reiterate this by recommending that patients be treated with respect and confidentiality and as individuals with specific needs.

The different recommendations are likely to improve the effectiveness of the consultation process if applied. Also, they can be applied not only to a medical consultation, but to other forms of communication, including the reference interview.

5.6 Summary

This Chapter comprised the discussion of the results of the study. The results were discussed with respect to the objectives of the study. The objectives entailed establishing the key tangible verbal communication problems (voice tone/attitude and language), the key tangible nonverbal communication problems (eye contact/culture, gestures, body postures, and facial expressions) and the key intangible communication problems (race, age, gender, education and culture). All these problems were discussed with respect to the data collected from both the patients and the healthcare workers of the Scottsville Clinic. Recommendations from both the patients and the healthcare workers were discussed. It was noted finally that if the recommendations (based mainly on the attitude of the healthcare workers) were taken into consideration, the effectiveness of the communication

process may be improved. The communication process pertains not only to that in the medical setting but to any other setting, including the reference interview.

CHAPTER SIX

CONCLUSION

In this chapter, a brief summary of the study will be given, followed by a conclusion of the most salient findings, as discussed in Chapter Five. Finally, some recommendations based on the findings of the study, as well as suggestions for further research, will be made.

6.1 Summary

This study has been an attempt to examine communication between a healthcare worker and a patient, with a view to identifying some of the problems which occur during the consultation process. The problems could either be tangible (verbal/nonverbal) or intangible, as perceived by Jennerich and Jennerich (1997). Tangible refers to clear, definite and real situations and intangible refers to situations that are not definite but are indirectly influential. Verbal is perceived in terms of words and nonverbal in terms of actions. Examples:

- Tangible nonverbal

  Eye contact/culture, gestures, body postures, and facial expressions.

- Tangible verbal

  Voice tone/attitude and language

- Intangibles

Race, age, education, gender and culture

In Chapter One, the introductory chapter, the purpose and objectives of the study were outlined. The different terms used in the study were discussed and defined. Communication within the context of the study was seen as a one-to-one process which could, for example, be between a healthcare worker and a patient, a reference librarian and a user or a husband and a wife. It was seen that for communication to be effective, certain techniques needed to be applied and certain barriers taken care of. The techniques and barriers with some variations were, in the main, common to a one-to-one communication process, irrespective of the parties concerned (though that between a healthcare and a patient was the one studied). Given that ineffective communication could lead to serious consequences, it was considered worthwhile to undertake such a study, which would not only bring out these vital issues but would make suggestions for improvement.

Chapter Two consisted of discussion of various issues relating to communication in general and to communication in the medical setting, in particular. Cases were cited of studies out of and within South Africa. The major areas of challenges in communication and what is expected of effective communication were discussed. Factors such as age, race, language, culture, education, gestures, postures and voice tone/attitude were seen as challenges in communication. What is expected of the parties concerned in order for

communication to be effective was outlined, for example the interviewer (healthcare worker) having the right posture, gesture and attitude and being versed in the culture and language of the patron.

In Chapter Three, the methodological perspective, method, data collection technique and sample population were discussed. It was established that the study took place in what could be considered a quantitative methodological perspective. The method and data collection technique which, according to Trow the "problem under investigation properly dictates..."(in Bulmer, 1977:15), were the survey and semi-structured interview (conducted with the patients), while data collection technique for the healthcare workers was a self-administered questionnaire. The sample population was made up of black female isiZulu-speaking patients of the ages18 and above.

The results of the study were listed in Chapter Four and discussed in Chapter Five. What follows are some concluding remarks of the most salient findings.

6.2 Conclusions

The over-riding factors of communication in the study were voice tone/attitude, eye contact, facial expression, sitting position, gestures, gender and language. For the sake of effective concentration and free flow of information, patients preferred healthcare workers who were polite, had a cheerful look and who sat still and straight up (not looking around

or standing). This is because the majority of the patients acknowledged such healthcare workers and were not satisfied with those who behaved otherwise. In relation to previous consultations (irrespective of the Clinics), out of the 70 respondents who encountered problems, 61 (87%) cited cases of rudeness, of which the majority of such cases were from black healthcare workers. Culture mattered more when seen in terms of people being able to speak the same language and understand one another with respect to the contextual meaning of words. Otherwise, when related to eye contact, it was apparent that adjustments had been made.

It was discovered that in as much the Zulu culture does not approve of eye contact especially between the young and the old, Zulus have come to accept it as they are now in a multi-cultural South Africa. Their acceptance of eye contact was seen as due to the advantages of it, such as that it is indicative of attentiveness and also confidence that one is being heard and understood better.

6.3 Recommendations

From the findings of this study as a whole, it was observed that the following areas needed major attention:

- **Attitude (of the healthcare workers with respect to the immediate and previous consultations).** For the immediate consultation, healthcare workers are recommended by the patients to maintain a caring, welcoming and receptive spirit. The healthcare workers reiterate this by recommending that patients be treated with

respect and confidentiality and as individuals with specific needs. In relation to previous consultations (irrespective of the Clinic), it was noted that most of the healthcare workers (especially the blacks) were rude, cheeky and uncooperative. It was also noted that some of the healthcare workers treat patients differently with respect to looks, colour, educational and social status. The researcher therefore recommends that healthcare workers be mindful of their conduct and their patients, irrespective of who they are and where they come from. They should treat others the way they will want to be treated and, as put by Green (1976: 78), they should maintain a courteous disposition, and be cheerful, patient and sympathetic.

- **Language and cultural differences.** Effort should be made, especially on the part of healthcare workers, to speak the dominant language of the patients. For example, in connection with this study, they should make an effort to speak isiZulu given that it is the dominant language of the patients who go for consultation at the Scottsville Clinic.

  The municipality should endeavour to employ more isiZulu-speaking female healthcare workers. This is because, only one of the consultant healthcare workers is a Black and can speak isiZulu (not "Fanakalo").

- **Eye contact/culture.** Given that most of the Zulu patients (irrespective of their culture) have come to accept the maintenance of eye contact due to its advantages, it

is recommended that healthcare workers should maintain eye contact during consultation. They should do so without necessarily judging the patient's background (race).

- **Time constraint and staff shortage.** With respect to shortage of staff, not enough time is given for effective consultation, some healthcare workers being in a hurry and patients having to wait for long hours, the researcher recommends the employment of more staff. The probability of budget constraints is, however, acknowledged.

If applied, the different recommendations are likely to improve the effectiveness of the consultation process. They can also be applied not only to a medical consultation but to other forms of communication, including the reference interview.

6.4. Suggestions for further research

- Given that this study was limited to black isiZulu-speaking females, a comparative study can be carried out with black isiZulu-speaking males.
- Comparative studies of healthcare worker and patient communication could be carried out in other clinics in South Africa (not necessarily in KwaZulu-Natal).
- Comparable research could be done into the reference librarian and user communication process.

- Although interpreters were not widely used in the Scottsville Clinic, research into the use of interpreters in medical consultation could be conducted.

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APPENDIX A : LETTER OF NOTIFICATION TO PATIENTS

COMMUNICATION BETWEEN HEALTHCARE WORKERS AND PATIENTS AT THE SCOTTSVILLE CLINIC PIETERMARITZBURG, SOUTH AFRICA.

PATIENT'S INTERVIEW

Dear Patient,

This interview is to be used in the collection of information on communication between healthcare workers and patients like you, that come to the Scottsville Clinic for consultation. The information collected will help in identifying communication problems experienced in the consultation process. It is hoped that the results of the interview will inform healthcare workers, information managers and other concerned authorities, in the better management of the communication process for effective transfer of information. All information acquired through this interview will be treated in **strictest confidence** and used in the preparation of a thesis in partial fulfilment of a Master of Information Studies degree at the University of Natal.

Sincerely

Nyamboli MB

School of Human and Social Studies

University of Natal, Private Bag X01

Pietermaritzburg 3209

July 2000

APPENDIX B : PATIENT'S INTERVIEW SCHEDULE

COMMUNICATION BETWEEN HEALTHCARE WORKERS AND PATIENTS AT THE SCOTTSVILLE CLINIC PIETERMARITZBURG, SOUTH AFRICA.

Instructions

- Please answer the questions as honestly as you can
- Please also remember that there are no right or wrong answers.

Thank you for co-operation

How old are you in terms of the following categories?

1. 1.1. 18-30 ☐ 1.2. 31-40 ☐ 1.3. 40 and above ☐

2. Gender: 2.1. Male ☐ 2.1. Female ☐

3. Do you have a job? 3.1. Yes ☐ 3.1. No ☐

4. If 'Yes', what is your job?.....

5. In the following languages, please indicate the one(s) you can effectively communicate in

5.1. isiZulu ☐ 5.2. English ☐ 5.3. Afrikaans ☐ 5.4. 0thers?.....

6. Many people in SA, did not have not have the opportunity to go to school. Did you go to school?

6.1. 'Yes' ☐ 6.2. 'No' ☐

7. If 'Yes', what is your highest qualification? .....

8. What I want to do now is give you a list of factors which could possibly have an effect on communication between you and the healthcare worker.

8.1. Does the age of the healthcare worker matter? 8.1.1 'Yes' ☐ 8.1.2 'NO' ☐

8.2. If 'Yes' why do you think so?.....

.....

8.3. Does the gender of the healthcare worker matter? 8.3.1 'Yes' ☐ 8.3.2 'NO' ☐

8.4. If 'Yes' why do you think so?.....

8.5. Does the race of the healthcare worker matter? 8.5.1 'Yes' ☐ 8.5.2 'NO' ☐

8.6. If 'Yes' why do you think so?.....

.....

8.7. Does the language used by the healthcare worker matter? 8.7.1 'Yes' ☐ 8.7.2 'NO' ☐

8.8. If 'Yes' why do you think so?.....

.....

What I want to do now is ask you questions about the consultation you have just had with the healthcare worker.

9. How did you explain your health problem to the healthcare worker?

9.1. Through an interpreter ☐

9.2. By describing it personally ☐

(If through an interpreter, go to question (28) and proceed from there).

10. If you described your problem personally, in what language did you describe it?

10.1. isiZulu ☐ 10.3. Afrikaans ☐

10.2. English ☐ 10.4.

Other?.....

11. Do you think the healthcare worker understood you well? 11.1.Yes ☐ 11.2. No ☐.

12. If (No), why do you think she did not?

Prompt: Because of language differences ?

Any other reason?.....

13. Did you on the other hand understand the healthcare worker well? 13.1. Yes ☐ 13.2. No ☐

14. If (No),why not?

Prompts: Because of language differences?

Because of the medical language used by the healthcare worker?

Any other reason?

.....

I want to now ask you some questions relating to the reaction and position of the

Healthcare worker during the consultation.

15.Was the healthcare worker looking into your eyes when talking to you? 15.1.Yes ☐

15.2. No ☐

16. Can you tell me how you consider that?

Prompts: Polite? ..... Not polite?.....

Why do you say so .....

17. What was the sitting position of the healthcare worker?

17.1. Leaned towards you ☐

17.2. Leaned backwards ☐

17.3. Sat straight up ☐

17.4 Other?..... ☐

18. How did you consider that?

Prompts: Polite?..... Not polite?.....

19.What was the reaction of the healthcare worker concerning your situation?

Prompts: Showed concern ?..... Indifferent?.....

20. Why do you say so?.....

.....

21. How did the healthcare look during the consultation?

Prompts: Friendly?..... Not friendly?.....

22. Why do you say so?.....

.....

23. Can you tell me what the healthcare worker was doing during the consultation?

Prompts: Sitting still?..... Tapping the pen?..... Looking around?.....

Any thing else?.....

24. How do you consider that?

Prompts: Polite?..... Not polite?..... .....

25. Why do you say so?.....

26.How did the healthcare worker speak to you?

26.1 Politely ..... 26.2 Not politely.....

27. Why do you say so?.....

28. Were you satisfied with the consultation? 28.1. Yes ☐ 28.2. No ☐

29. If (No) please can you tell me why?.....

30.What suggestions/recommendations would you like to make concerning the consultation which you have just had?

.....

31. Bearing in mind what we have just talked about is there anything else you would like to say about previous consultations?.....

What we have done so far is talked about what just took place during the consultation.

Now what I want to do now is ask few questions of general interest.

32. Are there things that you do not openly talk about? 32.1. Yes ☐ 32.2. No ☐

33. If (Yes), what are some?.....

34 Do you think the healthcare worker treats patients differently? 34.1.Yes ☐ 34.2. No ☐

35. If (Yes), why do you say so?.....

MANY THANKS FOR YOUR TIME AND EFFORT

APPENDIX C

PATIENT'S INTERVIEW SCHEDULE IN isiZulu

Ucwaningo ngeziguli ukuxhumana phakathi kwabasebenzi bezempilo neziguli Scottville Clinic Pietermaritzburg, South Africa

Ucwaningo ngeziguli

ukuxhumana phakathi kwabasebenzi bezempilo neziguli

Scottville Clinic Pietermaritzburg, South Africa

Imiyalelo

* uyacelwa ukuba uphendule imibuzo ngokwethembeka

* uyaziswa ukuthi ayikho impendulo eyiyo noma ekungeyiyo

Ngiyabonga ubambiswano lwakho

Uneminyaka emingaki uma ungakhetha kule enikwe ngenzansi

1. 1.1 18-30 1.2 31-40 1.3 40 nangaphezulu

2. Ubulili 2.1 ungowesilisa 2.2 ungowesifazane

3. Uyasebenza na? 3.1 yebo 3.2 cha

4.uma usebenza wenza msebenzi muni?.....

5. Kulezi zilimi ezingenzansi, khombisa olulodwa okwazi ukulukhuluma kahle kakhulu?

5.1 isiZulu 5.2 English 5.3 afrikaans 5.4 Others?.....

6. Abantu abaningi e South Africa abalitholanga ithuba lokuya ezikoleni. Wena waya esikoleni?

6.1 yebo 6.2 cha

7. Uma waya wagcina kuliphi ibanga?.....

8. Manje ngizokunika izinto ezingaba nomphumela ongemuhle ekuxoxisaneni phakathi komsebenzi wezempilo nesiguli

8.1 Iminyaka (omdala noma omncane) yosebenzela ezempilo yenza umehluko ? 8.1.1 Yebo 8.1.2 cha

8.2 Uma uthi yebo chaza ukuthi yini usho njalo?.....

8. 3 Ubulili (ukuthi owesilisa noma owesifazane) benza umehluko noma kukunika inkinga?

8.3.1Yebo 8.3.2 cha

8.4 Uma uthi yebo chaza ukuthi yini usho njalo?.....

.....

8.5 Uhlanga(ukuthi Umzulu Umlungu Indiya ikhaladi) kweza umehluko noma kukunika inkinga?

8.5.1 yebo 8.5.2 Cha

8.6 Uma uthi yebo chaza ukuthi yini usho njalo?.....

8.7 Ulimi olusetshenziswa osebenzela ezempilo luyakunika inkinga?

8.7.1 Yebu 8.7.2 Cha

8.8 Uma uthi yebo chaza ukuthi yini usho njalo?.....

Manje ngizokubuza imibuzo emayelana nokuza kwakho lapha njengamanje njengoba uzobonana nabasebenzi bezempilo.

9.Uyichaze kanjani inkinga yakho kwabezempilo (konesi)?

9.1 Ngokutolikelwa omunye umuntu

9.2 ngokuzisholo wena

(Uma kade utolikelwa dlula eminye imibuzo uye embuzweni 28 bese uqhubeka njalo)

10. Uma uzisholo wena inkinga yakho uluphi ulimi olusebenzisile?

10.1 isiZulu

10.2 isiNgisi

10.3 isiBhunu

10.4

Olunye?.....

11. Uma ucabanga owezemplilo (unesi) ukuzwile kahle impela? 11.1 Yebo11.2 Cha

12. Uma uthi cha , ucabanga ukuthi wenziwe yini angezwa kahle hle?

Kungaba ukuthi: Ulimi lwenu alufani

Esinye isizathu esidale lokhu?.....

13. Ucabanga ukuthi nawe owezempilo (unesi) umuuzwe kahle impela? 13.1 Yebo

13.2cha

14.Uma uthi cha, ucabanga ukuthi kwenziwe yini lokho?

Kungaba ukuti ulimi lwanu alufani?

Kungaba ukuthi Unesi usebezise amanye amagama ezifo ongawazi kahle hle?

Esinye isizathu esidala lokhu?.....

Manje ngizokubuza imibuzo emayelana nempatho nesimo ayiso owezempilo (unesi) ngenkathi nixoxisana naye.

15. Owezempilo (unesi) ubekubuka emehlweni ngenkathi nikhuluma? 15.1 Yebo 15.2 Cha

16. ngokubona kwakho kunjani lokho?

Kungabe: kuyemukeleka..... Akumukeleki.....

Chaza ukuthi yini usho njalo.....

17.Indlela abehlezi ngayo? 17.1 ubesonele kuwe

17.2 ubencike emuva

17.3 ubehlezi eqondile

18.ukubone kunjani lokhu

Kwemukelekile?.....

Akumukelekile?.....

19. Indlela akuthathe ngayo mayelana nesimo oze ngaso?

Kungaba: ukhombisa ukuzwelana nawe..... noma wehlukile.....

20. Yini usho njalo?.....

21. Ubebukeka enjani owezempilo (unesi) ngenkathi nixoxisana naye?

Kungaba: unomusa ?..... Akakhombisi umusa?.....

22. Yini usho njalo?.....

23.ngenkathi nixoxisana ubenzani okunye unesi?

Kungabe: ubelokhu ehleli?..... Ubedlalisa ipeni?..... Ubeqalaza ngapha nangapha?.....

24. ukubone kunjani lokho?.....

Kungabe kwemukelekile?.....

Akumukelekile?.....

25. yini usho njalo?.....

26. Indlela akhuluma ngayo unesi kungabe yemukelekile ?.....

Ayimukelekile?.....

27 yini usho njalo?.....

28.ugculisekile usizi akusize ngalo? 28.1 Yebo 28.2 Cha

29 Uma uthi cha , yisho isizathu?.....

30. Yikuphi okunye ongakusho ofuna kwenziwe mayelana no.kuza kwakho lapha kwabezempilo?.....

31. kungabe kukhona okunye ongakusho mayelana nokuza kwabezempilo(emakiliniki, ezibhedlela) lapho usake waya khona phambilini.....

Esikwenzile manje ukukubuza mayelana nokuza kwakho kwabezempilo, manje ngizokubuza ngokunye okungaphathelene nezempilo (kungaba ngenxa yesiko lakho)?

32. Ikhona yini into noma ngabe yini onga kwazi ukuyikhuluma ukhululeke nanoma ubani?

32.1 Yebo 32.2 Cha

33. Uma uthi yebo yisho okunye kwako?.....

34. Uma ucabanga onesi baziphatha ngokungefani iziguli? 34.1 Yebo 34.2 Cha

35. Uma uthi yebo usho ngobani noma kwenziwa yini lokho?.....

NGIYABONGA IMIZAMO, ISIKHATHI NESINEKE ONGIPHE SONA

APPENDIX D: LETTER OF NOTIFICATION TO HEALTHCARE WORKERS

COMMUNICATION BETWEEN HEALTHCARE WORKERS AND PATIENTS

COMMUNICATION AT SCOTTSVILLE CLINIC PIETERMARITZBURG

SOUTH AFRICA

Dear healthcare workers,

The purpose of this interview is to collect information on communication between healthcare workers and patients of the Scottsville Clinic. The information collected will help in identifying communication problems experienced in the consultation process. It is hoped that the result of the interview, will inform healthcare workers in general, information managers and other concerned authorities, in the better management of the communication process for effective transfer of information. All information acquired through this interview will be treated in **strictest confidence** and used in the preparation of a thesis in partial fulfilment of a Master of Information Studies degree at the University of Natal. Your cooperation is much appreciated.

Sincerely

Nyamboli MB

School of Human and Social Studies

University of Natal, Private Bag X01

Pietermaritzburg 3209

July 2000

APPENDIX E

HEALTHCARE WORKER'S QUESTIONNAIRE

COMMUNICATION BETWEEN HEALTHCARE WORKERS AND PATIENTS AT THE SCOTTSVILLE CLINIC PIETERMARITZBURG, SOUTH AFRICA.

Instructions

- Please answer the questions as honestly as possible.
- Please also remember that there are no right or wrong answers.

Thank you for co-operation

1. Gender: 1.1. Male ☐ 1.2. Female ☐

2 Race: 3.1. Indian ☐ 3.3. White ☐

3.2. Black ☐ 3.5. Coloured ☐

3.6. Other?.....

3 Age: 2.1. 19-30 ☐ 2.2. 31-40 ☐ 2.3. 40 and above ☐

4. What is your qualification?.....

5. On average, how many hours do you work per day at the clinic?

5.1. 1-3 hrs ☐ 5.2. 4-6 ☐ 5.3. 7 -9 ☐ 5.4. 9 and above ☐

6.On average, how many patients do you attend to per day at the clinic? 6.1. 10 and below ☐ 6.2. 11 - 20 ☐ 6.3. 21-30 ☐ 6.4. 31-40 ☐ 6.5. 40 and above ☐

7. How do you feel about that? .....

8. Given the following languages, please indicate the ones you can effectively communicate in

8.1. English ☐ 8.2. Afrikaans ☐ 8.3. isiZulu ☐. Others? .....

9. What kind of language related problems do you encounter during consultation?

Prompt: What about patients not understanding you?.....Anything else?.....

10. How do you respond to the problem(s) (List each problem)?

10.1.....

10.2.....

10.3.....

What type of culture related problems do you encounter during consultation?

11. How do you respond to the problem(s) (List each problem)?

11.1.....

11.2.....

11.3.....

12. What I want to do now is give you a list of factors which could possibly have an effect on communication between you and the healthcare worker.

12.1. Does the age of the patient matter? 12.1.1 'Yes' ☐ 12.1.2 'NO' ☐

12.2. If 'Yes' why do you think so?.....

12.3. Does the gender of the patient matter? 12.3.1 'Yes' ☐ 12.3.2 'NO' ☐

12.4. If 'Yes' why do you think so?.....

12.5. Does the race of the patient matter? 12.5.1 'Yes' ☐ 12.5.2 'NO' ☐

12.6. If 'Yes' why do you think so?.....

12.7. Does the language of the patient matter? 12.7.1 'Yes' ☐ 12.7.2 'NO' ☐

12.8. If 'Yes' why do you think so?.....

12.9. Does the social status of the patient matter? 12.9.1 'Yes' ☐ 12.9.2 'NO' ☐

12.10. If 'Yes' why do you think so?.....

12.11. Does the educational level of the patient matter? 12.11.1 'Yes' ☐ 12.11.2 'NO' ☐

12.12. If 'Yes' why do you think so?.....

13. Do you feel that patients withhold or feel reluctant releasing certain information?

13.1. Yes ☐ 13.2. 13.3. No ☐

14. If (Yes), what are some of the information about?.. .....

15. What recommendations/suggestions would you wish to make concerning consultation?

.....

MANY THANKS FOR YOUR TIME AND EFFORT