

**EXPERIENCES OF HEALTH CARE WORKERS  
REGARDING MAINTENANCE OF CONFIDENTIALITY  
CONCERNING HEARING CHALLENGED PEOPLE IN  
SELECTED PUBLIC HEALTH SETTINGS IN ETHEKWINI  
DISTRICT, KWAZULU-NATAL**

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Sciences in the Faculty of Health Sciences at the Durban University of  
Technology

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## **Declaration**

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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Signature of student

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Date

Approved for final submission

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## **Abstract**

### **Background**

Communication between a health care provider and a patient is a pre-requisite for any intervention to occur in the process of health care. Deaf patients depend on interpreters when seeking health care. Confidentiality is an issue since interpreters are involved in the Deaf community. Health care workers (HCWs) are tasked to ensure that the delivery of information to the patient is accurate and kept confidential.

### **Aim of the study**

The aim of the study was to explore and describe the experiences of HCWs regarding maintenance of confidentiality concerning hearing challenged people in selected public health settings in eThekweni District, KwaZulu-Natal in South Africa.

### **Methodology**

A descriptive exploratory qualitative design was used in this study. The study population comprised health care workers who worked with hearing challenged patients. Purposive sampling, which is a type of non-probability sampling, was used to select the study participants from the population. Structured interviews, using an interview schedule, were used to collect data. Data was collected until data saturation was reached. Data was analysed using Tesch's eight steps of thematic analysis.

### **Findings**

Six major themes that emerged from the data analysis were (a) training of health care workers, (b) communication preferences for hard of hearing patients, (c) communication challenges, (d) health care worker-patient relationship, (e) involvement of family members as interpreters and (f) measures to maintain confidentiality. The findings revealed that the majority of participants experienced

communication challenges with patients who are hard of hearing since only few HCWs are trained in sign language.

## **Conclusion**

The findings of this study will contribute to addressing issues related to the maintenance of confidentiality of hard of hearing patients. This study does not claim to exhaust the subject but to raise awareness of new investigations in other realities. Further research in the larger representative population of HCWs and hard of hearing patients is necessary to make the health care system more accessible and communication with HCWs more satisfying and effective. A doctoral study is necessary to develop a practice framework to facilitate communication between hard of hearing patients and HCWs.

**Key words:** Communication barriers, confidentiality, deaf, hard of hearing, health care workers, sign language.

## **Dedication**

I dedicate this dissertation to the Almighty God who has given me strength and wisdom to embark on this journey to pursue one of my goals.

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This has been a long journey, which I could not have completed without the support of some people and I would like to dearly acknowledge them. May God bless them.

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## **Glossary of terms**

### **Breach of confidentiality**

It occurs when a patient's privacy of information is disclosed to a third party without their consent (Ljubcic *et al* 2017: 2).

### **Communication barriers**

It is anything that prevents a person from receiving and understanding the messages others use to convey their information, ideas and thoughts (Naseribooriabadi *et al.* 2017: 1469).

### **Confidentiality**

Confidentiality is a form of informational privacy characterized by a special relationship such as the physician-patient relationship and the personal information obtained during this relationship should not be revealed to others without patient consent (Gichane *et al.* 2017: 438).

### **Deaf**

This term is used to describe one segment of the individuals who have a hearing impairment. People who identify themselves as *Deaf* with capital “D” and use sign language as their primary means of communication. Most have severe to profound hearing loss (Brianna 2008: 7).

### **Deaf culture**

It is used to describe people who identify as culturally Deaf and are actively engaged with the Deaf community (Bukowski 2015: 9).

### **Disability**

It is a physical or mental condition that limits a person's movements, senses or activities (Gichane *et al.* 2017: 434).

**Experience**

It is knowledge or skill in a particular activity that a person gains after a long time doing it (Daher *et al.* 2017: 8).

**Hard of hearing**

People who have moderate hearing losses who are still able to understand readily fluent speech through hearing whether amplification is used (Danford 2010: 6).

**Health care worker**

A person who delivers care services to the sick and ailing either directly as doctors and nurses or indirectly as aides, helpers, laboratory technicians or even medical waste handlers (Kuenburg *et al.* 2015: 2).

**Hearing challenged**

It is also known as hearing impairment, which is a partial or total inability to hear (Simasiku and Nghitanwa 2017: 83).

**Interpretation**

It is an act of explaining, reframing, or otherwise showing your own understanding of something (Demers 2005: 24).

**Sign language**

A system of communication using visual gestures and signs as used by deaf people (Mutenwa 2011: 13).

**Therapeutic relationship**

Refers to the relationship between a health care professional and a patient (Van de Heever *et al.* 2013: 3).

## Acronyms

Acronym	Full word/sentence
ADA	African Deaf Association
ADH	Addington Hospital
AIDS	Acquired Immune Deficiency Syndrome
DeafSA	Deaf South Africa
ENT	Ear Nose and Throat
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
IALCH	Inkosi Albert Luthuli Central Hospital
KZN	KwaZulu-Natal
MDG	Millennium Development Goals
SMS	Short Message Service
TISSA	Telephone Interpreting Service for South Africa
PHC	Primary Health Care
UK	United Kingdom
WHO	World Health Organisation



# **CHAPTER 1: OVERVIEW OF THE STUDY**

## **1.1 INTRODUCTION AND BACKGROUND TO THE STUDY**

Patient confidentiality is a vital attribute of professional practice that safeguards patients' rights. Health care workers (HCWs) have a code of ethics and practice guidelines that govern the management of confidential information. Most deaf patients depend on interpreters when seeking health care, as they experience communication barriers with health care providers (Dickson and Magowan 2014: 12). Richardson (2014: 24) argues that confidentiality remains an issue especially since interpreters are typically already involved in the deaf community and might know the individual personally.

Patient confidentiality was introduced in the International Code of Medical Ethics in 1948 to produce a modern medical code for use worldwide. It aimed to support and maintain patient confidentiality and to provide clarification of a doctor's duty in this area. Patient confidentiality is not introduced in medical practice only, but also exists for various medical professional and international ethical codes worldwide, such as the Geneva Declaration (1949). McClelland and Thomas (2002: 291) claim that patient confidentiality is a very old concept from the early days of medicine, which can be traced back over 2000 years to the Hippocratic Oath. Patient confidentiality is an ancient concept, which goes back to ancient Egypt and to the physician Imhotep, who used to make his students take an oath not to divulge any secrets of their patients. Later, the Greek physician Hippocrates established the Hippocratic Oath for Doctors, which serves as a guideline for the modern medical profession code of ethics (McClelland and Thomas 2002: 293).

Patient confidentiality is a form of informational privacy characterized by a special relationship such as the physician-patient relationship and the personal information obtained during this relationship should not be revealed to others without patient consent (Richardson 2014: 24). Confidentiality relates to the concept that private and personal information must be kept secret and protected from any breach of security, which might occur (McClelland and Thomas 2002: 292). While one may be liable for invading a person's privacy, only those with information gained from the special confidential relationship have a duty to maintain its confidentiality, not share it without the patient's permission or in the absence of a compelling reason to do so. Confidentiality protects informational privacy interests by requiring receivers of information to restrict access to that information (Blightman *et al.* 2014: 53).

Patient confidentiality is a vital attribute of professional practice that safeguards patients' rights. It is deeply rooted in the codes of ethics and law and contributes to the duty of caring for a patient. The obligation to preserve and not reveal patient's information is both ethical and statutory for all HCWs (Ataiyero and Ajiteru 2015: 14). The South African Department of Health identified four requirements to provide a patient with a confidential service (South Africa. Department of Health 2003: 31). These entail protection of patient information; ensuring that only those who are directly involved in the patient's care gain access to their medical records; giving the patient adequate information about how their health cannot be disclosed to a third party; and lastly improvement of the first three requirements to achieve the best possible ways to protect, inform and provide choice by the patient.

Patient confidentiality also applies to computer and electronic records, which are being used in some developed countries. Patient information is very sensitive, so the prevention of disclosure and the preservation of personal information leads to the development of trust and confidence between HCWs and patients, strengthening the relationship. A relationship based on trust maintains a patient's

dignity and respects his/her faith and this encourages the patient to communicate openly and honestly with the HCWs about their illnesses (O'Brien and Charter 2003: 37). According to Rortveit *et al* (2015: 196), trust is essential between the health care worker and the patient. Health care professionals have a code of ethics and practice guidelines that govern the management of confidential information (UK Department of Health 2007).

## **1.2 PROBLEM STATEMENT**

Dimitra *et al.* (2014: 102) states that people with disabilities have less access to health care services and therefore experience unmet health care needs. The international and local prevalence of deafness and hearing loss means that a significant proportion of the population face serious barriers in health care (Kay 2008: 15). Only few health care professionals have been trained in communication with deaf patients (Dickson and Magowan 2014: 12). Most deaf patients depend on interpreters when seeking health care, as they experience communication barriers with health care providers (Dickson and Magowan 2014: 12).

There is an inadequate supply of interpreters to serve deaf people in South Africa. As of 2016, there were only five interpreters in South Africa, registered and accredited in the South African Sign Language (SASL) by the South African Translators Institute, for the estimated 500 000 to 1.5 million SASL users in the country (Gichane *et al.* 2017: 435). The inclusion of an interpreter in an interview introduces two or more relationships to the consultation, which can have the effect of altering the usual therapeutic relationship. However, Agrawal *et al.* (2008: 1522) state that the use of an interpreter can affect ethical standards and patient's confidentiality and privacy. Richardson (2014: 24) argues that confidentiality remains an issue especially since SASL interpreters are involved in the deaf community and might know the individual personally.

### **1.3 AIM OF THE STUDY**

The aim of the study was to explore and describe the experiences of HCWs regarding maintenance of confidentiality concerning hearing challenged people in selected public health settings in eThekweni District, KwaZulu-Natal (KZN) in South Africa.

### **1.4 RESEARCH QUESTIONS**

#### **1.4.1 Grand tour question**

The grand tour question that guided the study was:

- What are the experiences of HCWs regarding maintenance of confidentiality concerning hearing challenged people in selected public health settings in eThekweni District, KZN?

#### **1.4.2 Sub-questions**

- What measures are used by HCWs to maintain confidentiality for hard of hearing patients in public hospitals?
- How do HCWs communicate with hard of hearing patients?
- What is the significance of maintaining patient confidentiality for hard of hearing patients?
- What is the effectiveness of communication between HCWs and hard of hearing patients?
- What are the effects of having an interpreter as a third person during consultation with a hard of hearing patient?

### **1.5 SIGNIFICANCE OF THE STUDY**

Confidentiality is ensuring that information is accessible for reading, listening, recording or physical removal only to people entitled to it and that they only read or listen to the information to the extent permitted (Hammer and Schneider 2007:

337). Patient confidentiality is well acknowledged worldwide as a valuable principle that is worth protecting (Hammer and Schneider 2007: 337). HCWs are tasked to ensure that the delivery of information to the patient is accurate and that his/her privacy is kept confidential. HCWs usually have a code of ethics and practice guidelines that govern the management of confidential information.

In South Africa, most encounters are often conducted in English, which complicates further the health seeking experience of the non-English speaking deaf patient who also has limited access to health education as compared to the hearing patient. According to Zulu (2014: 10), communication between a HCW and the patient is a pre-requisite for any meaningful intervention to occur in the process of seeking health care. Effective communication is essential for both the patient who needs to express himself/herself in terms of symptoms, complaints and for the HCW who must be able to explain treatment protocols, preventative options and make a diagnosis for treating any condition that may be affecting the patient's physical, emotional or social well-being (Kritzinger 2011: 13). However, most HCWs are unable to communicate effectively with hearing challenged patients (Yates 2017: 25). Only few HCWs have been trained on communication with deaf patients.

Even though there is a growing number of health programmes and research initiatives for the deaf, accessing primary care for deaf and hard of hearing people is still very often challenging (Kuenburg 2016: 2). Deaf people experience challenges accessing health care because of problems in communicating with their health care providers who are not trained in sign language (Reeves and Kokoruwe 2005: 95). Pereira and Fortes (2010: 34) argue that deaf adults often report experiences of feeling embarrassed in health settings and consequently, many avoid health care altogether.

## **1.6 STRUCTURE OF THE DISSERTATION**

**CHAPTER 1:** Background and introduction to the study.

**CHAPTER 2:** Literature review.

**CHAPTER 3:** Theoretical framework.

**CHAPTER 4:** Research design and methodology.

**CHAPTER 5:** Presentation of findings.

**CHAPTER 6:** Discussion of findings.

**CHAPTER 7:** Conclusion, limitation and recommendations of the study.

## **1.7 SUMMARY OF THE CHAPTER**

This chapter presented the orientation of the study which included the background and introduction, problem statement, research question, significance of the study as well as the structure of the dissertation. Chapter 2 will present the literature review.

## **CHAPTER 2: LITERATURE REVIEW**

### **2.1 INTRODUCTION**

The literature review will be presented in this chapter. Literature review is a critical summary of research on a topic of interest, often prepared to contextualise a research problem. (Polit and Beck 2008: 757). This is a review of the literature on the significance of patient confidentiality in health care.

### **2.2 PROCESS OF SOURCING RELEVANT LITERATURE**

The process of reviewing literature included the use of computers conduct searches on a number of electronic databases that provide a broad scope of literature, nationally, and internationally, enabling access to relevant sources (Brink *et al* 2016: 74). Various libraries were used to source relevant books on the topic. Relevant sources were identified firstly, by the clarification of the research topic, identifying the key words and concepts and all relevant publications in the area of interest. After identifying the sources, the list of the sources was organised. All the acquired sources were critically evaluated and used to write up a literature review and references were systematically recorded. The following search engines were used to identify relevant articles: Google Scholar, Research Gate and general sources such as the library and published dissertations. The following key words were used: confidentiality, maintenance of patient confidentiality, patient confidentiality for hard of hearing people, communication between HCWs and hard of hearing people and health care access for hard of hearing people.

## **2.3 GLOBAL VIEW ON MAINTAINANCE OF CONFIDENTIALITY FOR HARD OF HEARING PEOPLE**

In India, patient confidentiality is recognized as a polar concept, with the patient's right at one end and the protection of patient information on the other end. Patient confidentiality in India is part of medical law that patient's medical information is kept secure and safe. Rao (2007: 15) states that the common trend in India is for patients to be accompanied by close family, opening a wide discussion. He adds that, in India the close family members form a shield around the patient and the health workers sometimes deal with the family members much more than the patient. Health workers do not have the right to disclose any kind of personal information regarding the patient, during or after the patient's consultation, because this would be breaching confidentiality, which according to the Indian law must be maintained (Priyadhareshini 2011: 4). HCWs are prohibited to pass any medical information to any person without the patient's consent because it is the patient's fundamental right to keep the information confidential. Where the practice is for family members to be involved, the conversations between the patient, his/her family and the health worker is still documented in a confidential manner.

According to Corkill (2011: 34), the patient- HCW relationship is the core of clinical medicine and respect for patient secrecy brought about the best outcomes for patients in New Zealand. This author further states that confidentiality and privacy follow when HCWs respect patients and when stability is maintained between the patient's legal and compulsory rights (Corkill 2011: 36). The way the HCW and the patient communicate with each other is also significant in building a secure and strong relationship. He emphasizes that communication has always been important in patient-health worker's relationship and noted as a necessity for the treatment to be effective. HCWs should also make patients feel comfortable when discussing their concerns and without good communication this is impossible. The use of language must be taken into consideration and may introduce the need to



involve a third party in medical discussion, but not without securing the patient's permission. (Corkill 2011: 35).

In the United Kingdom (UK), patient confidentiality is seen as the patient's individual right to protection with the National Health Trusts. Patient confidentiality is practiced under strict legal and ethical obligation (Nortje and de Jongh 2016: 31). Notable legislation related to patient confidentiality includes the Data Protection Act (1998) which came into force in March 2000 and aims to protect personal data and information from being disclosed to third parties. Patient information in the medical record must be kept confidential and private during the lifetime of a patient and even after the patient had died (Nortje and de Jongh 2016: 31).

It is compulsory for HCWs in the UK to protect patient data and to respect patient privacy and autonomy. The current system in the UK is continuously evolving to guarantee the maintenance of patient confidentiality (United Kingdom General Medical Council 2017:58). Sharing patient information with third parties is controlled and restricted and the amount of information released depends on the patient's consent. In the Chinese hospitals any person who requires access to patient information must follow the stipulated procedure and complete a special form that is fully checked by the hospital managers. Patient centredness is assessed on the dimensions of communication, autonomy, dignity and confidentiality (Wang *et al* 2019: 1).

## **2.4 CONTEXT OF CONFIDENTIALITY FOR HARD OF HEARING PEOPLE IN SOUTH AFRICA**

According to the Deaf South African (DeafSA), there are between 500 000 and 600 000 South Africans that use SASL for communication. This is about 20% of the disabled people in South Africa (Van Herreweghe and Vermeerbergen 2010: 130). The deaf community in South Africa has a high unemployment rate and is

functionally illiterate. Deaf people use SASL as their primary language to communicate. Their cultural identity is defined by the use of SASL. Services in sign language are limited in South Africa, but there have been attempts to bridge the gap by including the sign language interpretation.

A deaf person's visit to a health care setting illustrates the need for communication aid to provide clear and intelligible communication between a deaf person and a hearing person. An incorrect comprehension of symptoms may lead to an incorrect diagnosis. Looijesteijin (2009: 25) designed a mock-up that allowed deaf people and hearing people to communicate with each other using pre-recorded SASL videos. This mock-up is called Sign Support.

Deaf people struggle to communicate with hearing people. There are limited methods in South Africa to aid deaf people to communicate with hearing people. Hiring an interpreter needs to be arranged ahead of time, is expensive and there are not enough interpreters. Even though interpreters are bound by a code of conduct to maintain confidentiality, it is still a concern in medical situations. Although there are communication methods such as short message service (SMS), relay services, video internet and Telephone Interpreting Service for South Africa (TISSA) that deaf people can use, these systems are text-based and hence not ideal for deaf people, are expensive or simply not available in South Africa. Deaf people in South Africa use sign language to communicate with hearing people especially for public services such as health care (Mutenwa 2011: 32).

#### **2.4.1 Influence of culture**

The international and local prevalence of deafness and hearing loss means that a significant proportion of the population face serious barriers in health care (Kay 2008: 15). The hearing culture does not recognize the deaf as a culture and ignores its unique needs (Sirch *et al.* 2017: 368). The hearing population perceives deafness as a medical disability and believes that only hearing-impaired persons

who are fully integrated into the hearing world will be successful. The deaf community shares common characteristics with other minority groups. They bond through sports, socials, artistic expressions, political organisations, community and shared oppression (Kay 2008: 9).

Cultural values and beliefs play a significant role in patient health. Part of a patient's culture includes language. Using the language connected to the patient's culture in health care is crucial. The distinction between groups of the hearing loss community such the deaf or hard of hearing needs to be better understood in healthcare (Pereira and Fortes 2010: 36). According to Karras *et al.* (2011: 204), very few HCWs receive training related to deaf cultural issues nor do they know or understand sign language enough to communicate with patients. Professionals are expected to educate themselves about potential cross-cultural barriers and develop the skills necessary to avoid the adverse effects of poor communication.

Peters (2007: 583) lists the following as considerations for HCWs when working with deaf/hard of hearing patients: awareness of deaf culture, attention to non-verbal behaviour, focus on wellness, confidentiality, and sign language interpreters. He mentions that understanding deaf culture is very important and may be crucial when considering working with this population. Kuenburg *et al.* (2015: 4) believes that cultural competency training can contribute to providing better health service accessibility for the deaf.

#### **2.4.2 Influence of language**

Language is part of the culture. Sign language is the natural language of the deaf community, and like spoken language is complex, grammatical and nuanced. The use of sign language is a mark of identification with deaf culture and ethnicity, and for significant numbers of deaf people. It functions as their primary language. People who are deaf may use hearing aid devices, spoken language and sign language (Penn and de Andrade 2017: 59).

According to the DeafSA, the federation of South Africa approximately 500 000 South Africans use sign language in their daily lives (Magongwa 2010: 493). The SASL is not one of the official languages but “sign language” is mentioned openly in the Constitution of the Republic of South Africa, adopted on the 8th of May 1996, as one of the other languages in South Africa that must be promoted and adequate conditions for its ongoing development and use must be created (Constitution of the Republic of South Africa Act, No 108 of 1996: 1257). South African Schools Act 1996, states that a recognized Sign Language has the status of an official language for purposes of learning at a public-school (Constitution of the Republic of South Africa Act, No 108 of 1996: 1257). The SASL has the status of medium of instruction in schools that specifically cater for the needs of deaf pupils (Van Herreweghe and Vermeerbergen 2010: 130). Despite the provisions of the South African Constitution, language services to all is not implemented.

### **2.4.3 Communication**

The meaning of *communication* differs, depending on the context in which it is used in everyday life. For example, social communication should also include therapeutic elements (Kritzinger 2011: 13). The ability to communicate well and effectively should be one of the most important skills for nurse-patient communication. Providing qualitative nursing care is one of the goals of modern nursing and secures satisfaction of needs in all types of patients (Kritzinger 2011: 13).

Language plays a crucial role in the assessment, treatment and management of health patients from culturally and linguistically diverse groups of people (Kritzinger 2011: 14). Effective communication is essential for both, the patients who needs to express themselves in terms of symptoms, complaints, and for the health care provider who must be able to explain treatment protocols, preventative options and make diagnoses for treating any condition that may be affecting the patients' physical, emotional or social well-being. One of the major difficulties is the inability

of health professionals to communicate directly with deaf/hard of hearing patients. It is essential to acknowledge that the majority, if not all professionals, are hearing and thus do not know how to sign. This creates a greater gap in communication between deaf/hard of hearing and hearing individuals. Interpreters play a central role in making health services accessible to deaf consumers (Kritzninger 2011: 14).

According to Lezzoni, O'Day, Killeen and Harker (2004: 358), there are guidelines to follow when interacting with hard of hearing patients who prefer communicating through sign language. These guidelines include ensuring that the HCW gets the patient's attention before speaking, speaking slowly and clearly, looking directly when speaking to the patient, maintaining eye contact with the hard of hearing patient, being courteous during the conversation and using open-ended questions. These authors further argue that, although some hearing HCWs may know a few signs, they often do not know enough sign language to communicate effectively in a treatment session with a hard of hearing patient.

In South Africa, most encounters are often conducted in English, which further complicates the health-seeking experience of the non-English speaking deaf patient who also has limited access to health education as compared to the hearing patient. Most HCWs are unable to communicate effectively with hearing challenged patients (Yates 2017: 25). Only few HCWs have been trained on communication with deaf patients. Most deaf patients depend on interpreters when seeking health care, as they experience communication barriers with health care providers (Dickson and Magowan 2014: 12). Communication barriers appear to be most commonly expressed by deaf people. They are also at risk of receiving inadequate health care and health related information because of limitations of communication between the deaf person and the HCWs (Ljubicic *et al* 2017: 1). Better communication is not an option, barrier-free communication is regarded as

a basic human right and vital to patient safety. Communication challenges leave many deaf adults reluctant to seek health care (Fusick 2008: 104).

## **2.5 CONFIDENTIALITY**

Confidentiality is important in any patient-HCW relationship, regardless of the population group. Explaining confidentiality upfront is helpful when building trust with the client (Gichane *et al.* 2017: 438). Confidentiality is a form of informational privacy characterized by a special relationship such as the physician-patient relationship and the personal information obtained during this relationship should not be revealed to others without patient consent. HCWs, like nurses, have the responsibility to provide health services to patients.

HCWs are tasked to ensure that the delivery of information to the patient is accurate and that it is confidential. Richardson (2014: 24), argues that confidentiality remains an issue especially since interpreters are involved in the deaf community and might know the individual personally. The deaf community is a small community with defined familial, professional and social networks. This implies the need to explain and reinforce the need to protect the participants' rights to anonymity and confidentiality (Penn and Andrade 2017: 60).

Having a family member present without a patient's consent violates patient-provider confidentiality, a right established by the South African Government's National Health Act 2003 (Gichane *et al.* 2017: 438). The family members may also be unaware of the need for maintaining confidentiality of patient information. Using an unqualified interpreter may violate privacy and confidentiality provisions of the Health Insurance Portability and Accountability Act of 1996 (Shuler *et al.* 2013: 27).

## 2.6 INTERPRETERS

The concerns that are consistently noted in research are the lack of hiring a qualified interpreter as well as the concerns of confidentiality being maintained on the part of an interpreter (Lezzoni *et.al.* 2004: 359). The ability to sign does not qualify an individual as an interpreter. Interpreters are professionals who abide by the national code of ethics and guidelines with confidentiality as one of the ethical components (Demers 2005: 205). Interpreting is the process of understanding and analysing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another language, taking into account the cultural and social context.

The Deaf Federation of South Africa (DeafSA) claims that approximately 500 000 South Africans use a sign language in their daily lives. The majority of these are both audiological and culturally deaf. Audiological deafness relates to a person who has little or no functional hearing but depends upon the visual sense rather than the auditory sense (Mnyandu 2016: 8). Cultural deafness relates to an individual who identifies with and participates in the language, culture and community of deaf people, based on signed language (Mnyandu 2016: 8). Deaf individuals using sign language have been seen as a threat to the medical profession as they challenge the professionals own value system and their ability to communicate with deaf people using sign language. Deaf people see no value in being part of the hearing world when they are not accepted for who they are and are forced to assimilate into a culture that views their deafness as a disability rather than a way of life (Briana 2008: 4). The inclusion of an interpreter in a consultation introduces two or more relationships. Even though interpreters are bound by rules of confidentiality and impartiality, deaf people may have concerns about confidentiality.

## 2.7 HEALTH CARE ACCESS

Levesque, Harris, and Russell (2013: 18) define health care access as access to a service, a provider or health care facility, whereby there is an opportunity for health care customers to use suitable services relating to their health needs. Dimitra *et al.* (2014: 102) argue that people with disabilities have less access to health care services and therefore experience unmet health care needs. Over five percent (5%) of the global population, 360 million people are facing hearing problems or are deaf. They also state that people with hearing problems have poorer health, use the health services in a different way comparing to the general population, are unsatisfied by their communication with the health professionals, are less satisfied with the health services they receive, do not receive sufficient messages related to preventive health care and have a deficiency in knowledge of health matters compared to hearing people. There are a growing number of deaf health programmes and research initiatives but accessing primary care for deaf people is still very challenging. Deaf people are entitled to use health facilities like the general population without being discriminated (Simasiku and Nghitanwa 2017: 82). Dickson and Mogavan (2014: 13) state that the difficulties experienced by deaf people trying to access health care begin at reception, where their need to communicate and orientate themselves and to have an interpreter often goes unrecognised.

According to Gichane *et al.* (2017: 436), those without access to interpreters often rely on friends or family members which can pose many ethical and human rights issues. According to the African Deaf Association (ADA), HCWs are responsible for ensuring that the deaf patients reasonably accommodated (Shuler *et al.* 2013: 27). The HCWs should consider asking their deaf patients about their perception of need and preferences for these services before entering the medical centre. Services such as providing a qualified sign language interpreter or comparable alternatives and to arrange and pay for interpretation services should be offered.



## **2.8 SUMMARY OF THE CHAPTER**

This chapter presented the orientation of the study which entailed the process of sourcing relevant literature about the maintenance of confidentiality in a global context and in the South African context. It also highlighted other relevant sub-topics such as the influence of culture, language, communication, interpreters, and confidentiality as health care access regarding hard of hearing people.

## **CHAPTER 3: THEORETICAL FRAMEWORK**

### **3.1 INTRODUCTION**

A framework is a set of ideas that you use when you are making decisions and judgements (Tavallaei and Abu Talib 2010:575). A theory can be successfully used to make predictions and this predictive power of the theory can help guide researchers to ask appropriate research questions. This research study used Peplau's Interpersonal Relations Theory, which is an interactional model that is concerned with interpersonal relationships (Figure 3.1).

### **3.2 THEORETICAL FRAMEWORK USED AS A GUIDE**

Theoretical framework is based on propositional statements resulting from an existing theory. Theory guides and generates ideas for research and research assesses the worth of existing theory and provides a foundation for new theory. Theories allow researchers to put together observations and facts in an orderly manner. They guide the researcher's understanding not only of the phenomena of interest but also of the reasons behind the occurrence of these phenomena. Theory and research are mutually beneficial. Theory-research relationship is linked within each series of events in the theory-research process. The relationship is like a cyclic chain in which theory directs research, research corrects theory and corrected theory directs further research (Brink *et al.* 2016: 30).

A framework is a set of ideas that is used when making decisions and judgements. A theory can be successfully used to make predictions and this predictive power of the theory can help guide researchers to ask appropriate research questions. Tavallei and Abu Talib (2010: 571) state that the relationship between the qualitative research and theory is both complex and contentious and numerous scholars have alluded to the lack of consensus and poor understandings that reflect this troubled marriage. Theory in qualitative

research is variable and can be used in different ways. Integration of theory and research is essential. Theory is crucial and without it, the quality of qualitative research is diminished (Anfara and Mertz 2006: 21).

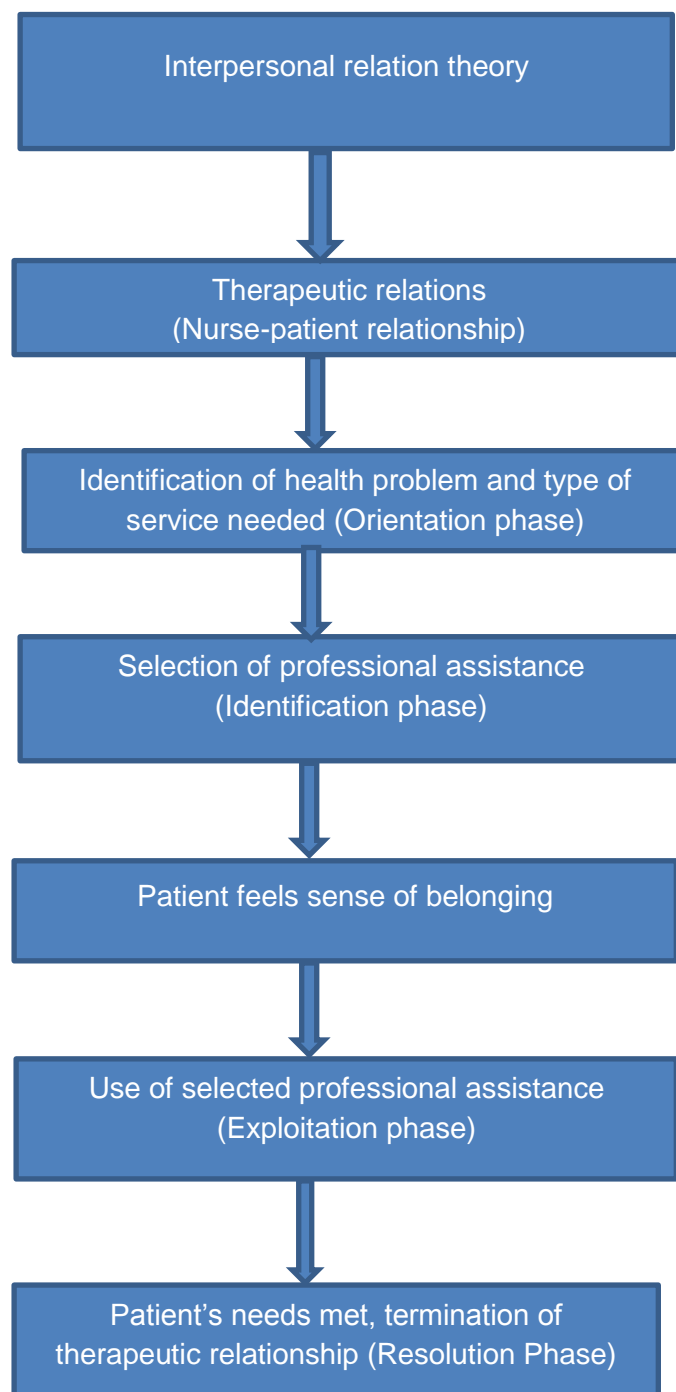
This research study used Peplau's Interpersonal Relations Theory which is an interactional model that is concerned with interpersonal relationships (Figure 3.1). For hard of hearing patients to have quality of health care including maintenance of confidentiality, an effective and a therapeutic relationship between the HCW, the sign language interpreter and the patient is significant.

### **3.3 APPLICATION OF PEPLAU'S INTERPERSONAL RELATIONS THEORY**

This research study used Peplau's Interpersonal Relations Theory which is an interactional model that is concerned with interpersonal relationships (Figure 3.1). Jooste (2018: 18) states that nursing is organised through building relationships to support communication and the nurse must be able to use herself therapeutically. It focuses on the nurse-patient therapeutic relationship. The HCWs need to identify the health problem which is the hearing problem and a type of service needed which is an interpreter. They must then select a qualified and professional interpreter to meet the communication needs of the hard of hearing patient. For hard of hearing patients to have quality of health care including maintenance of confidentiality an effective and a therapeutic relationship between the HCW, the sign language interpreter and the patient is significant. The hard of hearing patient will assume dependence, interdependence or independence and sense of belonging in relation to the HCW. Power will then shift from the HCW to the hard of hearing patient in taking what the HCW offers through the relationship and the patient uses available and selected services based on their needs and self-interest, which can be getting a sign language interpreter to assist in the consultation. When the presented needs or health problems have been met and resolved, newer and mature ones emerge, with the presence of an interpreter the patient can now

communicate the real reason for seeking health care. The health care practitioner should play multiple roles to help patients and their needs.

Further details on how the framework was applied in the study will be incorporated under the discussion of the findings in Chapter 6.



**Figure 3.1: Diagram depicting the application of Peplau's Interpersonal Relations Theory**

### **3.4 SUMMARY OF THE CHAPTER**

This chapter presented the orientation of the study, which discussed the theoretical framework used to guide this study.

## **CHAPTER 4: RESEARCH DESIGN AND METHODOLOGY**

### **4.1 INTRODUCTION**

The aim of the research was to explore and describe the experiences of HCWs regarding maintenance of confidentiality for hard of hearing patients. In order to achieve this an appropriate research design was chosen. This chapter will present the research design as well as the methodology that was used to conduct the study. Methodology refers to the methods of obtaining, organising and analysing data (Polit and Beck 2008: 758).

### **4.2 RESEARCH DESIGN**

Research design is the plan for gathering data in a research study (Brink *et al.* 2016: 217). A qualitative, exploratory, descriptive design was used to explore the experiences of HCWs regarding the maintenance of confidentiality for hard of hearing patients.

#### **4.2.1 Qualitative research**

Qualitative research approach refers to the broad range of research designs and methods used to study the phenomena of social action where there is no understanding (Babbie and Mouton 2001: 270). The research design was chosen to explore and provide an in-depth understanding of HCWs experiences regarding the maintenance of confidentiality of hard of hearing people. This research design offers a flexible yet structured approach in obtaining rich data about people's perspectives about any phenomena that are unexplored. It is widely used in social science research, education and health care. The qualitative research method enabled the researcher to be involved as an active participant of the process. The aim is to give the participants a voice to interpret and represent their experiences in a coherent way that could be analysed by the researcher. (Fidan 2017: 58). The qualitative research method was selected as an effective way to inform related fields and to contribute to what is already

known regarding the maintenance of confidentiality of hearing challenged patients.

#### **4.2.2 Exploratory research**

Exploratory research is defined as research that is conducted to gain new insights, discover new ideas and increase knowledge of the phenomenon (Blanche *et al.* 2006: 559). Polit and Beck (2012: 18) argue that exploratory research is conducted to identify a specific problem in an area of interest where there is insufficient knowledge, with the goal of providing a new strategy to solve the problem for that specific topic of interest. Grove *et al.* (2013: 66) agree that this specific lack of knowledge can only be best addressed by seeking the viewpoints held by members of the group. This research method was chosen to explore the experiences of HCWs regarding the maintenance of confidentiality for hard of hearing patients. Secondly, the exploratory research was selected to satisfy the researcher's curiosity regarding HCWs experiences, as little was understood regarding the maintenance of confidentiality of hard of hearing patients.

#### **4.2.3 Descriptive research**

Descriptive research is a method in which the phenomenon that is being studied is discussed (Blanche *et al.* 2007: 558). Descriptive research provides an in-depth description of participants' experiences in a narrative type description. Through descriptive studies, the researcher can discover new meaning, describe what exists, determine the frequency with which something occurs and categorise information. This design was chosen for this study because the researcher needed to know more about the topic under study and establish a basis for further research. The researcher was thus able to describe the experiences of the HCWs regarding the maintenance of confidentiality for hard of hearing patients.

#### **4.2.4 RESEARCH PARADIGM**

Research paradigms are set of scientific different beliefs, values and techniques for deciding which questions are interesting, how one should break down a question into solvable parts and how to interpret the relationship of those parts to the answers. The paradigm used in this research is the “Interpretivism”. It is the belief that the social world is actively constructed by human beings and that we are continuously involved in interpreting the social environment. The HCW’s experiences were studied which could only be understood by exploring the context in which it takes place and also studying the thinking processes when dealing with hard of hearing patients. The focus was to gain subjective experience in order to understand the challenges they face while working with hard of hearing patients affecting factors to how they maintain confidentiality in health care facilities. This research studied subjective experiences through flexible interaction through conversations with the HCW’s to represent reality as closely as possible, which gave an insight into how and why they use certain techniques to maintain confidentiality for hard of hearing patients.

#### **4.3 STUDY SETTING**

Research setting is the location and conditions in which data collection takes place in a study (Polit and Beck 2008: 766). This research study was conducted at two hospitals in eThekweni District. For confidentiality purposes, IALCH was coded as Hospital A and ADH as Hospital B. These hospitals were selected because the hard of hearing patients from various deaf societies and organisations are often referred to these hospitals as they have specialised Ear, Nose and Throat (ENT) outpatient units as well as audiology departments. Hospital A is the only tertiary, central hospital in KZN with medical disciplines, surgical disciplines, mother and child health services as well as professions allied to medical support disciplines. Hospital B is one of the districts and regional hospitals in KZN, located at the south beach in Durban, which offers various health services.



## **4.4 SAMPLING PROCESS**

### **4.4.1 Population**

Population is the entire group of people that is of interest to the researcher and that meet the criteria that the researcher is interested in studying (Brink *et al.* 2016: 131). This research study targeted a population of HCWs at a selected hospital who provide services to hard of hearing patients. HCWs are all people engaged in actions whose primary intent is to enhance health (Blanche *et al.* 2006: 562). A HCW is a person who delivers care and service to the sick and ailing either directly as doctors and nurses or indirectly as aides, helpers, laboratory technicians or even medical waste handlers (Joseph and Joseph 2016: 71). At Hospital A, there are eight (8) HCWs who provide services to hard of hearing patients in the ENT outpatient unit and at Hospital B, there are seven (7) HCWs who provide services to hard of hearing patients in the ENT outpatient unit. Thus, a total population of 15 HCWs.

### **4.4.2 Sampling technique and sample size**

Sampling refers to the process of selecting what to study and focusing on a portion of a population (Blanche *et al.* 2006: 564). Purposive sampling was used in this research study. Purposive sampling is a non-random technique also known as the judgement sampling. It is the deliberate choice of an informant due to the qualities the informant possesses. The researcher decides what needs to be known and sets out to find people who can and are willing to provide the information from their knowledge or experience (Tongco 2007: 147). HCWs in ENT clinics and audiology departments were purposively selected as they can offer experiences about working with hard of hearing patients. According to Brink *et al.* 2016: 133), a small sample size is required for a qualitative, exploratory study. Due to the small population size, all consenting HCWs were included in the sample. However, data collection was guided by data saturation. Data saturation is reached when there is enough information to replicate the study, when the ability to obtain new additional information has been attained and when further coding is no longer feasible.

#### **4.4.3 Inclusion criteria**

- Participants who provide health care to hard of hearing patients in ENT outpatient units and audiology departments.
- Experience of not less than 6 months in providing care to hard of hearing patients.

#### **4.4.4 Exclusion criteria**

- Participants who do not provide health care to hard of hearing patients.
- Less than 6 months' experience in providing care to hard of hearing patients.

### **4.5 DATA COLLECTION TOOL**

An interview guide was used to record the demographic data of the participants (Appendix 7a) and thereafter a semi-structured interview guide (Appendix 7b) was used to collect data. The interview is a two-person conversation initiated by the interviewer for the specific purpose of obtaining research relevant information. It is focused on content related to the research objectives. (Edward and Holland 2013: 1). The design of the data collection tool used was guided by the information gathered on the importance of patient confidentiality in health care, the significance of effective communication between a patient and a HCW, and the use of an interpreter in cases of patients who use sign language. Peplau's interpersonal relations theory also guided the design of the data collection tool in terms of developing questions to identify communication challenges HCWs face with hard of hearing patients.

### **4.6 DATA COLLECTION PROCESS**

Before the interview began, the participants were briefly introduced to the research project by the researcher. The introduction involved a concise overview of the research project and explanation of the requirements for participants. The participants were told of the importance of their involvement in this research study and once they were clear and understood the focus of the research they were required to read and sign the informed consent form

before the commencement of the interview (Appendix 6). The grand tour question was asked: “*What are your experiences regarding maintenance of confidentiality concerning hearing challenged people?*” Probing questions were used to facilitate the interview discussion and clarify certain responses as outlined in Appendix 7b. According to Kritzinger (2011: 43), probing is a characteristic of in-depth interviews. The use of probes in an interview is useful as the researcher get in-depth responses and without biasing later answers. Permission was sought from the participants to use a portable voice recorder during the interview sessions. Interview schedules were prepared in consultation with the participants and interviews were conducted at a time that was convenient to the participants. Each session of the interview took 30 to 45 minutes. A sample of a transcript is provided in Appendix 8.

#### **4.7 PRE-TESTING OF THE DATA COLLECTION TOOLS**

Pre-testing of the data collection tool was conducted including a few individuals who met the inclusion criteria but did not form part of the sample of the actual data collection. Pre-testing is the collection of data prior to the experimental intervention, sometimes called baseline data. It is the trial administration of a newly developed instrument to identify flaws and assess time requirement (Polit and Beck 2008: 762). The purpose was to check the feasibility of the instrument and detect possible flaws (Brink *et al.* 2016: 174).

#### **4.8 DATA ANALYSIS**

Data collected from the participants was analysed by using Tesch’s eight steps of thematic analysis as described in Creswell (2009: 186). These steps involved:

- Reading through all transcripts to get a general impression of the collected data.
- Writing down thoughts that emerged from the data.
- Making a list of all topics. Similar topics were clustered together. These topics were organised as major topics, unique topics and leftover topics.

- Abbreviating topics as codes were written next to the corresponding segments in the data. Any other topics or codes that emerged were written next to appropriate segment of the text.
- The most descriptive wording for the topics was used and turned into sub-categories.
- Grouping together of the related topics and emerging list of categories was done.
- Preliminary analysis of data was done by assembling data that belonged to each category from which themes emerged.
- Existing data were re-coded.

## **4.9 TRUSTWORTHINESS**

Trustworthiness is the believability of the researcher's findings (Lincoln and Guba 2000: 314). Credibility, transferability, dependability and confirmability are the key criteria for trustworthiness for a researcher to render a qualitative study credible. The researcher ensured trustworthiness in the study by using the following key criteria:

### **4.9.1 Credibility**

According to Lincoln and Guba (2000:314), credibility refers to the idea of internal consistency, where core issue is how we ensure rigor in the research process and how we communicate to others that we have done so. The researcher had prolonged engagements with the participants to gain an adequate understanding of the phenomena being studied and to establish a relationship with the participants. This was done through development of an early orientation to the culture of the participants before data collection dialogues took place. Credibility was also ensured through the use of a form of triangulation whereby participants' viewpoints and experiences were verified against others. A rich picture of experiences of the participants under scrutiny was constructed based on the contributions of a range of people. To ensure participants' honesty when contributing data, each participant was given an

opportunity to refuse to participate to ensure that data collection sessions involved only those who were genuinely willing to take part and prepared to offer data freely. Frequent debriefing sessions were conducted with the research project supervisor who helped bring attention to flaws in the proposed course of action and helped to identify the researcher's biases and preferences. Credibility was also ensured through 'member checks' relating to the accuracy of the data on the spot of data collection at the end of data collection interviews (Lincoln and Guba 2000: 333). Participants were asked to listen to the recorded interviews to ensure that information was accurately captured.

#### **4.9.2 Transferability**

Transferability is the ability to apply the findings of the study in other contexts or to other participants (Lincoln and Guba 2000: 316). A rich account of descriptive data was also provided such as the context in which the research was carried out, the setting, sample, sample size, type of sampling, inclusion and exclusion criteria, interview procedure and topics, changes in interview questions based on the research process and passages from the interview guide. This was done to enable the reader to assess whether the findings are transferable to their own setting, which is known as the transferability judgement. The study is trustworthy if and only if the reader of the research report judges it to be so (Anney 2014: 277).

#### **4.9.3 Dependability**

Dependability deals with the core issue of the way in which a study is conducted makes it consistent across time, researchers, and analysis techniques (Anney 2014: 277). The process through which findings are derived should be explicit and repeatable as much as possible. This was accomplished through carefully tracking the emerging research design and through keeping an audit trail, that is detailed chronologically, of research activities and processes, and influences on the data collection and analysis. The audit trail was thereafter examined by peer researchers and the supervisor who is an expert in the field. Throughout

the study, an audit trail was completed to demonstrate how each decision was made.

#### **4.9.4 Confirmability**

Confirmability refers to objectivity, the potential for congruence between two or more independent people about the data accuracy, relevance or meaning (Polit and Beck 2008: 539). This criterion is concerned with establishing data that represent the information participants provided and that the interpretation of those data are not fabrications of the inquirer's imagination. The interviews for this study were audio recorded to ensure that the information provided by the participants were accurate and truthful. The researcher interpreted and analysed the data through identifying themes and sub-themes, which were supported by the use of direct quotations from the interviews in order to eliminate subjectivity and bias.

#### **4.10 ETHICAL CONSIDERATIONS**

The study commenced when the researcher received full ethics clearance from the Institutional Research Ethics Committee (IREC) (IREC Number 098/19) (Appendix 1). Permission to conduct the study was sought and granted by the eThekweni District Health Manager (Appendices 2a and 2b), KZN Department of Health (Appendices 3a and 3b), and the Hospital Managers of the selected hospitals (Appendices 4a, 4b and 4c). The researcher ensured that the following fundamental ethical principles were adhered to:

##### **4.10.1 Right to self-determination (Autonomy)**

Self-determination principle means that prospective participants have the right to decide voluntarily whether to participate in a study without risking any penalty or prejudicial treatment (Blanche *et al.* 2006: 172). The participants were informed that they also had a right to withdraw from the study at any time, to refuse to give information or to ask for clarification about the purpose of the

study. This right was respected by avoiding any form of coercion (Brink *et al.* 2016: 32).

#### **4.10.2 Anonymity and confidentiality**

Anonymity literally means 'nameless' (Brink *et al.* 2016: 208). It is an act of keeping the participants' identities a secret, which regard to their participation in the research study. Data collected was not linked to the participants; instead codes were used to identify the part.

To ensure confidentiality, the information gathered during the study was not privately shared, divulged or made available to any other person without the participants' knowledge or against their will. If the information is published for the benefits of other researchers in the field, the participants will be informed and assured that their anonymity will be protected.

#### **4.10.3 Right to fair treatment (Justice)**

Justice is the principle of fairness. In research, it is a complex philosophical principle that researchers treat participants with fairness and equity during all stages of research (Polit and Beck 2008: 68). The study population was selected with fairness. The participants were not chosen because of their gender, age, ethnicity, or culture. The population was selected for reasons directly related to the study problem and not because they were readily available or could be easily manipulated. The researcher ensured that participants were provided with relevant information about the study (Appendix 5). The names of participants were coded and not made accessible to any other party.

#### **4.10.4 Right to protection from harm (Beneficence)**

Beneficence is a philosophical ethical principle that underlines the ethical obligation to do good or generate benefits for the participants in research (Polit and Beck 2008: 557). In order to adhere to this principle, the well-being of the

participants was ensured by informing them about their right to protection from discomfort and harm be it physical, emotional spiritual, economic, social or legal. (Brink *et al.* 2016: 32). Comfort of the participants was ensured during the study. Information that was provided by the participants was protected and not shared with other participants.

#### **4.11 SUMMARY OF THE CHAPTER**

In this chapter the orientation of the study, which entailed the research design, study setting, sampling process, inclusion and exclusion criteria, the data collection tool and data collection procedures, pre-testing the data collection tool, data analysis process was presented.



## CHAPTER 5: PRESENTATION OF FINDINGS

### 5.1 INTRODUCTION

The previous chapter presented the research design and methodology that guided the study. The current chapter will analyse the data gathered and present the findings.

### 5.2 DEMOGRAPHIC DATA

Face to face semi-structured interviews were conducted with 15 participants, four speech therapists and eleven nurses. Table 5.1 provides a summary of the demographic data of participants who participated in the study.

**Table 5.1: Demographic data**

Participant number	Age in years	Gender	Race	Designation	Years of experience in the current position
01	25	Female	Black	Speech Therapist/Audiologist	6 months
02	28	Female	Indian	Speech Therapist	4 years 8 months
03	36	Female	Indian	Audiologist	14 years
04	45	Female	Indian	Chief Speech Therapist/HOD	22 years
05	55	Female	Black	Nurse	7 years
06	35	Female	Black	Nurse	8 years
07	49	Female	Black	Nurse	8 years
08	37	Female	Black	Nurse	8 years
09	37	Female	Indian	Nurse	10 years
10	45	Female	Indian	Nurse	12 years
11	39	Female	Indian	Nurse	7 years
12	40	Female	Black	Nurse	5 years
13	52	Female	Black	Nurse	11 years
14	33	Female	Coloured	Nurse	9 years
15	28	Female	Indian	Nurse	5 years

### **5.3 PRESENTATION OF FINDINGS**

The following six major themes emerged from the data analysis:

- Theme 1: Training of HCWs.
- Theme 2: Communication preferences for hard of hearing patients.
- Theme 3: Involvement of family members during consultation.
- Theme 4: Communication challenges with hard of hearing patients.
- Theme 5: Measures to maintain confidentiality.
- Theme 6: HCWs' relationship with hard of hearing patients

The summary of the themes and sub-themes that emerged from data analysis are presented in Table 5.2.

**Table 5.2: Themes and sub-themes**

<b>Themes</b>	<b>Sub-themes</b>
5.4 Training of HCWs.	5.4.1 Minimal training of health care workers on SASL. 5.4.2 Lack of training of health care workers on SASL.
5.5 Communication preferences for hard of hearing patients.	5.5.1 The use of South African languages and African languages. 5.5.2 The effects of language barrier.
5.6 Involvement of family members during consultation.	5.6.1 Inclusion of family members. 5.6.2 Exclusion of family members.
5.7 Communication challenges with hard of hearing patients.	5.7.1 The use of other health care workers. 5.7.2 The use of gestures and writing.
5.8 Measures to maintain confidentiality.	5.8.1 Setting. 5.8.2 Information.
5.9 HCWs' relationship with hard of hearing patients	5.9.1 The influence of an interpreter as a third person. 5.9.2 Measures to ensure health care worker-patient relationship.

## **5.4 TRAINING OF HEALTH CARE WORKERS**

Participants expressed diverse opinions regarding training on SASL. The majority of participants verbalised that they received minimal training on SASL, whilst the minority indicated that they had not received training. These participants indicated lack of training as one of the reasons for not being comfortable communicating with patients.

#### **5.4.2 Minimal training of health care workers on SASL**

During the interviews, majority of the participants reported that they had minimal training on SASL, which they perceived as not adequate for effective communication with hard of hearing patients. This is evident in the excerpts below:

*“There’s different variations of sign language, so we may not know all the variations of sign language, they may come from different places as well. That is a problem where they use different signs for different words as compared to us.”* (Participant 04, Hospital B, Chief Speech Therapists/HOD).

*“We are comfortable with them because we have been trained how to assess and manage them, we did a small course at our university.”* (Participant 03, Hospital B, Audiologist).

*“My interaction with them some is pretty easy because I know sign language, and some may be pretty challenging especially if they not understanding written language. Usually the difficult cases, they usually come with somebody who can communicate with us verbally and even through written language to assist with interpretation. For me the issues come in when the patient now has limited vocabulary and when there’s issues in terms of cognition that is huge challenge for us.”* (Participant 04, Hospital B, Chief Speech Therapist/HOD).

*“So far I have never come across a case where it was just impossible to communicate or to get the necessary aim achieved. The big challenge would be the whole financial issue of having to go and come again for the second time if I could not get the message across.”* (Participant 03, Hospital B, Audiologist).

As noted below, one participant also raised a concern that few HCWs were selected for the SASL training, which further compromised their engagement with patients:

*“Only a few health care workers have been selected to go for the SASL course in the hospital, unfortunately I haven’t been selected.”* (Participant 01, Hospital B, Speech Therapist).

#### **5.4.3 Lack of training of health care workers on SASL**

Some participants reported their experiences of communication with hard of hearing patients with regard to their lack of training on SASL. They indicated that hard of hearing patients did not fully understand health education given, especially when they were not accompanied by a family member. This is noted in the following excerpts:

*“Patients with communication challenges often lack understanding during health education in instances of how to take medication in such a way that they even leave the medication behind out of frustration.”* (Participants 11, Hospital A, Nurse).

*“The experience of health care workers with hard of hearing patients is hard. However, we try to use writing most of the time if not see if they can lip read if all the forms of communication fail, we write a note and send the patient back home to come back with a family member. It is easier when the patient comes with a family member.”*. (Participant 07, Hospital A, Nurse).

*“It is hard but we try communicating using the self-taught sign language, maintaining the eye contact and try to read the facial expression to see if whatever you are saying they can understand, if they cannot understand you can see in their face but if they can hear or understand you can see even a smile.”*. (Participant 08, Hospital A, Nurse).

## **5.5 COMMUNICATION PREFERENCES FOR HARD OF HEARING PATIENTS**

This theme emerged as the participants described the preferences of communication with various patients who also come with various language backgrounds when seeking health care. The sub-themes were the use of South African languages and African languages and the effect of language barriers.

### **5.5.2 The use of South African languages and African languages**

The findings revealed that HCWs experienced challenges when treating a hard of hearing patient who uses a different South African language which the HCWs are not familiar with. The participants verbalised that it is also very challenging when they communicate with the patients who are foreigners who speak different African languages. They indicated how they check the patient's language preferences:

*“When the patient comes, we greet the patient, if they are African, I use IsiZulu to greet and if it is not an African person I will greet in English, then I will see when they respond which language they prefer to use. It is then that I will start communicating in that language but you find that sometime a patient will respond hesitantly only to find that they do not know the language you are greeting with then you ask if they are Sotho or Venda. If you know that language you start communicating with the patient but sometimes you find that a patient is deaf and cannot also understand the language that you are speaking which is a challenge.”* (Participant 09, Hospital A, Nurse).

*“It is a challenge when patients communicate in African languages because we do not know how to communicate in such languages its better when they know a little bit of English.”* (Participant 06, Hospital A, Nurse).

*“I have never found myself having a nurse to assist, when it comes to IsiZulu, the language barriers that often we had, we have the patients come with the family member.”* (Participant 02, Hospital B, Speech Therapist).

### **5.5.3 The effects of language barrier**

The participants expressed their experiences in terms of communication and the effect of language barrier in the following excerpts:

*“..... If on the first account they do not come with the family member, it is where it is a bit of a downer where I would write a letter for the family member or ask for a number or via their cell phone they will show you a number of a family member I will contact them asking them to come because they will have to come for different things such as re-evaluation, hearing aids and sometimes grant purposes etc.”* (Participant 01, Hospital B, Speech Therapist).

*“Definitely, when it comes to a second language if they are not first language English speakers because sometimes I do not know whether the family member is adequately interpreting the information and I do not know what tone is coming across in order to facilitate and enhance communication between the patient and I.”* (Participant 04, Hospital B, Chief Speech therapist/ HOD).

*“At the moment I work at this hospital where ninety percent of patients we see are foreigners, so it is a big concern. I did study isiZulu, so I am fine if a patient speaks isiZulu or Afrikaans. Foreigners speak French, Swahili, Somalia, Hiriq, Lingala and sometimes, they speak a language you have never heard before and I am a Speech Therapist and my role is communication, so it is definitely a big barrier.”* (Participant 02, Hospital B, Speech Therapist).

## **5.6 INVOLVEMENT OF FAMILY MEMBERS DURING CONSULTATION**

This theme emerged as the participants mentioned various measures that they use in order to maintain confidentiality for hard of hearing patients during consultations. They expressed that the involvement of family members does assist the hard of hearing patient in terms of interpreting but prior to the consultation, the patient is asked if the family member should be involved. The sub-themes include inclusion and exclusion of family members.

### **5.6.2 Inclusion of family members**

The participants reported that, before the family member enters the consultation room, the patient is asked for permission since private and confidential information is going to be discussed. However, some hard of hearing patients require that some information like the HIV status not to be discussed when the family member is involved. This is noted in the following excerpts:

*“.....when the patient cannot communicate in all forms cannot like read, write or understand whatever is being said, health care workers are forced to include the family member as an interpreter during consultation even if the patient can use sign language unfortunately no one in the department is trained on sign language.”* (Participant 05, Hospital A, Nurse).

*“When the patient is called for their turn for consultation they usually come with the family member because the doctor will have to talk with the family member to interpret to the patient, so that the patient can understand everything that is being said by the doctor, it does not happen that the patient comes on their own to the hospital.”* (Participant 02, Hospital A, Nurse).

*“If they are attending with the family member and if they like the family member to be in the session we would allow it, they have to be comfortable with the family member. We ask them if they would like the family member to come as well.”* (Participant 03, Hospital B, Audiologist).

### **5.6.3 Exclusion of family members**

The participants reported that the exclusion of family members during the consultation depends on the hard of hearing patient. However, they stated that it provides room for privacy of the patient's information especially when the relative who has been asked does not live with the patient at home. It is also a challenge when the patient cannot communicate directly with the HCW and



needs the assistance of the family member as an interpreter to translate the information being discussed or asked. This is noted in the following excerpts:

*“Exclusion of a family member sometimes is not right because things such as health education for aftercare at home and also for follow up care to the nearest clinic or at the same hospital can be hard for the hard of hearing patient to understand whereas with the family member can remind the patient.”* (Participant 08, Hospital A, Nurse).

*“We exclude the family member with the patients concern in which in most cases when a patient can communicate in some way mostly through writing down and when they come with a person who is not a family member and they do not want them to know about their confidential information.”* (Participant 13, Hospital A, Nurse).

## **5.7 COMMUNICATION CHALLENGES WITH HARD OF HEARING PATIENTS**

This theme emerged as the participants described strategies that they use to overcome communication challenges between hard of hearing patients. The sub-themes include the use of gestures and writing and the use of health care workers.

### **5.7.2 The use of gestures and writing**

Participants reported that they use various gestures and writing to communicate with those hard of hearing patients who are literate. They also use non-verbal language such as eye contact and looking directly at the patients who can lip read. Participants used the following ways:

*“..... the ones that use sign language, I use both sign language, gestures and lip reading, we have limited sign language but we use it like that, in cases where we really do not understand then we use the written mode of communication to communicate with them.”* (Participant 01, Hospital B, Speech Therapist).

*“For patients who are hard of hearing we raise our voices and maintain eye contact so that even if they did not clearly hear what you were saying they can at least read your lips. For patients who are deaf we also pay attention, maintain eye contact, read the patients facial expression to assess if what you are saying the patient can or cannot hear. We also try communicating through the little knowledge of sign language that we have tried to learn on our own.”* (Participant 12, Hospital A, Nurse).

*“We try speaking to them if that fails then its pen and paper, we try to use writing to understand what they require, any problems they are having, why they came to the hospital, and if they have an appointment.”* (Participant 15, Hospital A, Nurse).

*“First, verbally and then we try to use signs and gestures and if all of that fails then writing.”* (Participant 03, Hospital B, Audiologist).

### **5.7.3 The use of other health care workers**

The findings of the study revealed that HCW's, working with hard of hearing patients, use other health care workers in the hospital who are skilled on SASL to assist in interpretation, especially for patients who need to be given information before important procedures. This is noted in the following excerpts:

*“In instances where the patient communicates in South African or more especially African language and no one in the department can communicate with the patient, the hospital management sends an email around all departments for a health care worker who can communicate in that language to come and help interpret.”* (Participant 14, Hospital A, Nurse).

*“....you find that with patients who come from other countries we cannot communicate with them because we do know their language so it is hard to treat those patient when we cannot get an interpreter who knows the language,*

*so we ask other health care workers who know the language to assist.”* (Participant 10, Hospital A, Nurse).

*“There are cases where we are called in other departments to come and interpret for the patient who communicates in sign language, we attend them and help the patient.”* (Participant 01, Hospital A, Speech Therapist/Audiologist).

## **5.8 MEASURES TO MAINTAIN CONFIDENTIALITY**

This theme emerged as the participants revealed the measures that they use to maintain confidentiality during consultation with hard of hearing patients.

### **5.8.2 Setting**

The results revealed that all consultations were conducted in a closed and soundproof room with only the HCWs involved in the patient’s care present in the room. This is noted in the following excerpts:

*“.....closed rooms which are soundproof are used during consultation with the hard of hearing patients. Soundproof is important because sometimes we have to raise our voices for the patient to hear.”* (Participant 13, Hospital A, Nurse).

*“We normally see them in a closed environment, we also conduct our testing’s in a room away from everyone else and the feedback in the consultation room with the door close.”* (Participant 01, Hospital B, Speech Therapist/Audiologist).

*“The health care setting that we use admits one patient in a room per consultation which ensures that the other patients cannot hear what is being discussed about the patient during consultation.”* (Participant 06, Hospital A, Nurse).

### 5.8.3 Information

The participants shared their experience on the type of information they provide to the family members who are involved during the consultation to ensure that the patient's information is kept confidential. This is noted in the following excerpts:

*"Before they allow the family member to the consultation room with the patient, they ask first the relationship that person has with the patient. In cases where the person who is accompanying the patient is, maybe a neighbour not all information of the patient is exposed things such as the HIV status of the patient."* (Participant 15, hospital A, Nurse).

*"We ask the patient is there anything that you would not like us to discuss in front of a family member, then we inform the doctor not to discuss certain things like the HIV status however we still do need the family member to help interpret."* (Participant 06, Hospital A, Nurse).

*"In a paediatric case, it is different because the parents have to be involved in order to know everything that is happening regarding the child, so they have a right in the patients' care."* (Participant 02, Hospital A, Speech Therapist).

*"After the consultation I thoroughly explain to the family member who is involved in the consultation not to share whatever was being discussed with anyone unless they ask the patient for permission because the patient information is private and confidential."* (Participant 01, Hospital B, Speech Therapist/Audiologist).

## **5.9 HEALTH CARE WORKERS' RELATIONSHIP WITH HARD OF HEARING PATIENTS**

This theme emerged as the participants described their relationship with the hard of hearing patients. The sub-themes were the effect of an interpreter and the measures they use to ensure the health care worker-patient relationship especially when an interpreter such as a family member is involved.

### **5.9.2 Influence of an interpreter as a third person**

Participants expressed that it is a challenge to maintain their relationship with the hard of hearing patients when there is an interpreter involved as a third person in the consultation. They reported that it is time-consuming for the patient when the information is passed by the doctor to the nurse, to the interpreter and then to the hard of hearing patient. This is noted in the following excerpts:

*"The interpreter also plays the role on the after-care part where they need to help the patient about the food, they need to eat for example ensure soft diet."* (Participant 09, Hospital A, Nurse).

*"A simple thing as a smile, greeting your patient and asking how they are feeling today. You form a bond with the patient and connect in a professional way; you respect and listen the patient."* (Participant 06, Hospital B, Nurse).

*".....when I take history of the patient, I may come across as empathetic and wanting to help the patient but I do not know whether my questions are conveyed in that manner, so with experience for me always the third person becomes an issue because I just feel there needs to be a relationship and the bond between the patient and the clinician."* (Participant 04, Hospital B, Chief Speech Therapist/HOD).

*“Having an interpreter who is close to the hard of hearing patient helps during the consultation but it increases the time the patient spends in the consultation room because the doctor will pass a message to the nurse, the nurse to the interpreter who will then pass it to the patient. You find that even five minutes is spent on one question.”* (Participant 08, Hospital A, Nurse).

### **5.9.3 Measures to ensure health care worker-patient relationship**

Participants shared various strategies that they use to ensure that the health care worker-patient relationship is maintained despite having the family member present, during consultations, as an interpreter. This is shown in the following excerpts:

*“It’s a lot of gestures that I would use in my approach, my conduct, so it’s a lot of my behavioural attributes. When I’m presenting information and there is a third person, I will not present it to that family member, I will put it in front of the patient. I want each step of the way, if I said a sentence and I would look at the patient first say it in English or isiZulu and accompany it with sign language, so a total communication approach. The significant other should augment that communication that the way I do it.”* (Participant 04, Hospital B, Chief Speech Therapist/HOD).

*“I ensure that I keep eye contact and the focus on the hard of hearing patient is always maintained during a consultation especially when there is a proposed operation to be done to the patient, this is important because the patient needs to fully understand what is to be done and also what can happen if the operation is not done because the actual patient signs the consent form.”* (Participant 07, Hospital A, Nurse).

## **5.10SUMMARY OF THE CHAPTER**

In this chapter, the findings of the study were presented. These findings will be discussed in the next chapter with reference to the relevant literature that support or contradict the results and make recommendations to improve the maintenance of confidentiality for hard of hearing patients.

## **CHAPTER 6: DISCUSSION OF FINDINGS**

### **6.1 INTRODUCTION**

This chapter will interpret and describe the significance of the findings with regard to the maintenance of confidentiality for hearing challenged patients and explain any new understanding or insights that emerged as a result of the study. The study was guided by the objectives and the theoretical framework. The literature sources that were reviewed and new literature sources that are relevant will be incorporated to contextualise the meaning of themes and sub-themes that have developed and emerged during data analysis.

The six major themes will be discussed. Peplau's Interpersonal Relations Theoretical Framework will also be integrated in the discussion of findings.

### **6.2 TRAINING OF HEALTH CARE WORKERS**

The findings of the current study revealed that minimal training of HCWs was identified in the health care setting. Simasiku and Nghitanwa (2017: 82) concur that HCWs should be able to communicate effectively with deaf patients for effective quality nursing care. Only a few HCWs have been trained on communication with deaf and hard of hearing patients. They also state that effective communication between nurses and deaf patients is an essential element of nursing care yet nursing education on how to communicate with deaf patients is insufficient (Lubjubicic *et al.* 2017: 2). According to Machado *et al* (2015: 1825), nurses must be prepared to communicate with deaf patients through sign language. Although communication is emphasized as one of the most important basic tools of this profession, courses in sign language have not been included in the undergraduate nursing courses.



Participants indicated that lack of sign language training makes it difficult to communicate with deaf patients. This finding is supported by Machado's *et al* (2013) study in Rio de Janeiro, which found that most nurses did not understand sign language because they were not trained in sign language. A study by Alselai and Alrashed (2015: 84) found that HCWs were deficient in sign language due to lack of instructions in nursing schools, and training in the job on communication with hard of hearing patients. They further state that HCWs are insufficiently prepared to work with deaf patients whose primary mode of communication is sign language.

Sign language training for HCWs is the only way that can improve communication with deaf patients during the provision of health care. Through sign language communication the right information from the patients will be obtained and proper quality nursing care could be provided (Simasiku and Nghitanwa 2017: 84). The achievement of an inclusive health practice with regard to deaf patients is dependent on the basic understanding of sign language and cultural and linguistic particularities of the deaf community, which are considered essential skills that must be taught during academic training of these professionals. The South African Department of Health (2005) highlights the importance of training all front line HCWs in sign language to improve communication (Simasiku and Nghitanwa 2017: 85). The theoretical concept used in this theme was the identification of a health problem. HCWs lack training on sign language, which necessitates training for HCWs through their training years and at the health care settings.

### **6.3 COMMUNICATION PREFERENCES FOR HARD OF HEARING PATIENTS**

The findings revealed that HCWs struggle to communicate with hard of hearing patients who are South Africans, and especially those who are not from South Africa, because of the various languages which create a barrier. Hunter-Adams and Rother (2017: 6) agree that South Africa is a multilingual society with one official language and that many South Africans do not speak English. They add

that approximately 80% of health care consultations in South Africa are carried out across linguistic and cultural barriers, and the language barrier has become normative and even invisible. It compromises patient quality of care where those who cannot communicate with HCWs are less likely to adhere to treatment, to seek care or follow-up appointments or receive preventive services (Hunter-Adams and Rother 2017: 6). Orrie and Motsahi (2018: 209) further argue that HCWs rank language barriers between them and patients who speak other languages as a greater problem. Difference in language is a widely acknowledged as a major barrier to effective communication and accessing health care. When the nurse and the patient do not share a common language, interaction between them is strained and very limited (Sibiya 2018: 33).

Participants reported having difficulty with various languages in the health care setting. Machado *et al.* (2015: 19) argues that general and specific communication skills are needed by health professionals who work in the health care industry, both with normal and hearing-impaired patients. Language is an important enabler of right to health. It allows access to health care information, both preventative and curative, and allows for health care to be provided with informed consent from the user. Language is essential to developing a therapeutic relationship with a patient, yet language is a barrier between deaf patients and health care workers and is one of the main challenges in accessing health care (Orrie and Motsahi 2018:207).

According to Dickson and Magovan (2014: 14), nurses often communicate inappropriately and lack the knowledge and skills to understand the communication with deaf people. When a nurse in a health institution meets a patient with hearing impairment, efficient, mutually clear and understandable communication becomes a problem. Some of the participants indicated not feeling comfortable communicating with hard of hearing patients due to the lack of knowledge on SASL. According to Lubjubicic *et al* (2017: 5), a feeling of discomfort and insecurity indicates a need for education about ways of

communication with deaf people in order to reduce the difficulties and to develop better communication at mutual pleasure.

Machado *et al.* (2015: 19) states that communication is indicative of quality of life, therefore, when a health care professional knows how to communicate properly with deaf patients, they are promoting a humanized and focused assistance. The skills to deal with people who do not share oral language and culture in the world environment is not taught in schools. Professionals may not be prepared to meet the needs of these patients (Machado *et al.* 2015: 19). The theoretical concept applied from the Peplau's interpersonal relations theory is the identification of health problem which has been stated above by the participants, which is the language barrier that they experience with various patients who communicate in sign language in difference languages.

#### **6.4 INVOLVEMENT OF FAMILY MEMBERS DURING CONSULTATION**

Participants in the current study stated that they preferred using family members to interpret for the patient during consultations, as it easy to communicate with the hard of hearing patients and less time consuming. They also indicated having the hard of hearing patient to come with a family member to assist in communication. However, according to Ali (2012: 31), using family members as interpreters may impede both effective and physician/patient confidentiality.

The results of the study revealed that it is time consuming when the HCW communicates directly with hard of hearing patients, especially since only a few of them are trained on SASL. Other means of communication, like writing, also depend on whether the patient is literate. Due to lack of time, nurses sometimes avoid direct communication and communicate with a deaf person through an intermediary, most often a family member, although using family members can cause problems for patient confidentiality or in protecting the patient from dispiriting information (Hemsley *et al* 2012: 120).

Most interpreters, such as friends and family members, are informal. Family members are support for the deaf and hard of hearing patients, helping the patients to navigate the health care system and being an interpreter. However, it also became apparent that the family members provide valuable help to the HCWs themselves. HCWs actively seek them out because their presence makes the HCWs feel more comfortable and satisfied with the encounter (Orrie and Motsahi 2018: 207). While interpreters are helpful in overcoming language barriers, inappropriate use of family members as interpreters may rob a patient of his or her autonomy and the right to confidentiality (Orrie and Motsahi 2018: 207).

The findings of the study that was conducted by Blake *et al.* (2014: 12) revealed that deaf patients acquire health care knowledge from family members who may not have access to correct information either. This inaccurate information leaves the deaf patient with misunderstandings and misconceptions, which can have a long-term impact on their health (Blake *et al.* 2014: 15). In South Africa, common language practices to address in health care include involving the use of family members and nurses as informal interpreters (Benjamin *et al.* 2016: 75). The theoretical concept used in these themes is the identification of a health problem which is involving family members during consultation for hard of hearing patients which affects the patient privacy and confidentiality. However, trained sign language interpreters are needed for such a service.

## **6.5 COMMUNICATION CHALLENGES WITH HARD OF HEARING PATIENTS**

Participants in the study reported having communication challenges with hard of hearing patients and used gestures, writing and other health care workers to communicate. Using pen and paper is the main method used when health care workers communicate with deaf or hard of hearing patients. Alselai and Alrashed (2015: 84) argues that HCWs' skills in communicating with deaf and hard of hearing patients require attention.

Participants reported using writing and gestures to communicate with deaf patients (Machado *et al.* 2015:18). Writing is one of the best ways to get a message across to a deaf person, especially when speech does not seem to be conveying the desired message. (Alselai and Alrashed 2015: 84). Lack of professional medical interpretation affects adequate health care provision. This research shows that nurses communicate with deaf people mainly by gesturing and writing but cannot clearly assess if the deaf people have understood their message (Hunter-Adams and Rother 2017: 6).

Participants revealed that, sometimes, they have to raise their voices to pass a message to the hard of hearing patients. Hemsley *et al.* (2012: 118) argues that, although speaking louder to a deaf person or hard of hearing person is a natural inclination, it rarely, if ever, enhances comprehension. A profoundly deaf person will still hear nothing, no matter how loudly a message is spoken. He adds that, patients who wear hearing aids may experience both distortion and pain when shouting or when abnormally loud speech is amplified (Hemsley *et al.* 2012: 118). The theoretical concept applied in this theme was the identification of a health problem which were the communication challenges the HCWs have with hard of hearing patients.

## **6.6 MEASURES TO MAINTAIN CONFIDENTIALITY**

Participants revealed the various measures that they use to maintain confidentiality, such as providing information about confidentiality and ensure that the environment is suitable for hard of hearing to maintain confidentiality during consultations. Ajaj (2012: 216) concurs that hard of hearing patients should feel secure and protected when communicating with HCWs in safe and private conditions. Patient confidentiality should be carefully maintained, and this can be achieved by restricting the relationship between HCWs and the patient to the medical issue.

During consultation, everything communicated to the HCW and the hard of hearing or deaf patient, via a sign language interpreter, is considered to be confidential. When a family member is part of communicating the treatment plan to the hard of hearing patient, he or she is viewed as part of the health care team. They are advised to keep all medical information confidential (Steinberg *et al.* 2002: 266). Patient information is very sensitive, so the prevention of disclosure and preservation of personal information leads to development of trust and confidence between HCWs and hard of hearing patients and strengthens the relationship. In this theme the theoretical concept applied is the patient's sense of belonging which needs to be achieved by HCWs through maintaining confidentiality.

## **6.7 HEALTH CARE WORKERS' RELATIONSHIP WITH HARD OF HEARING PATIENTS**

Findings of the current study showed that HCWs preserve the HCW-patient relationship through various forms of communication, including non-verbal communication such as maintaining eye contact. HCWs who use facial expressions, gestures and animation to supplement spoken messages are generally more readily understood than those who do not. Facial expressions are also crucial in conveying the intensity of a message (Blake *et al.* 2014: 15). Orrie and Motsohi's (2018: 209) study findings corroborate with the findings of the current study in that hand gestures, signing and demonstrations are frequently used with most of the HCWs, showing enthusiasm for sign language. They further state that this a valuable skill as deaf patients recognise the use of basic signing as a genuine attempt by the HCWs to achieve good communication, furthering the development of a therapeutic bond.

According to Ajaj (2012: 216), trust between HCWs and the patients is usually the pioneer of a strong relationship in which mutual respect emerges, which protects patient's medical confidentiality. HCWs adopted many strategies to encourage better communication. They speak slowly and clearly, maintain eye contact, raise their voices when appropriate and speak to the better hearing ear

(Orrie and Motsohi 2018: 209). The theoretical concept from the Peplau's interpersonal relations theoretical framework used in this theme is the nurse-patient relationship. In this case, it includes the relationship between HCWs and hard of hearing patients which ought to be maintained despite the communication challenges the participants experience.

## **6.8 SUMMARY OF THE CHAPTER**

In this chapter study findings were interpreted and discussed with reference to the themes and sub-themes that emerged. Relevant literature was used to support or oppose the findings of the study. Theoretical concepts of Peplau's theoretical framework was applied in this chapter.

## **CHAPTER 7: CONCLUSION, LIMITATIONS AND RECOMMENDATIONS OF THE STUDY**

### **7.1 INTRODUCTION OF THE CHAPTER**

This chapter presents the conclusion, limitations of the study and recommendations that need to be considered in improving the maintenance of confidentiality for hearing challenged people in public hospitals.

### **7.2 CONCLUSION OF THE STUDY**

Confidentiality is one of the rights of people who enter the health care environment. However, for the selected population, this right is very often denied. This research study focused on the South African case, issues of communication and confidentiality between HCWs and hard of hearing or deaf patients. In this study, it emerged that there are practically no professional interpreters available at public hospitals. More often, friends and family are used as interpreters, which breaches the patients right to confidentiality. HCWs face various communication challenges with hard of hearing patients, which include language barriers, lack of sign language training, involving family members to interpret which makes it hard to preserve the HCW-patient relationship and to maintain confidentiality.

### **7.3 LIMITATIONS**

Limitations are barriers or constraints that weaken or decrease the credibility of the study results. These could be the research design, sample of the study or research methods (Botma *et al.* 2010: 107; Burns and Grove 2011: 48). This research has, to a large extent, achieved its aim and objectives. However, as with many other research studies, it is subject to several limitations. HCWs, like doctors, were not available for participation since they were occupied with work. The research study was conducted on HCWs in ENT departments only,



excluding other areas. The study was confined to the experiences of HWCs only, excluding experiences of hard of hearing patients. The study was limited to eThekwin District. Therefore, the findings and recommendations cannot be generalised to other settings.

## **7.4 RECOMMENDATIONS**

Recommendations of the current study could help to enhance the maintenance of confidentiality for hard of hearing patients in the public hospitals in KZN. The following recommendations based on the findings of the study are made with special reference to provision of sign language training, reduction of unqualified interpreters, deaf-friendly health facilities and further research.

### **7.4.1 Training of sign language interpreters**

- Department of Health, in collaboration with Department of Higher Education and Training, should consider introducing basic sign language studies in the curriculum for basic, secondary level, and tertiary level so that graduates at each level will be equipped with basic sign language communication.
- In order to enhance the use of sign language, policy should be directed and enforced for all HCWs to acquire the necessary education on basic sign language within the working environment and during their training school sessions.

### **7.4.2 Role of public hospitals**

- Public hospitals should employ qualified sign language interpreters in each health facility to assist during consultations to avoid the involvement and use of family members as interpreters, which impedes the hard of hearing patient's confidentiality.

#### **7.4.3 Improvement of facilities for the people who are deaf**

- The government should provide more schools for the deaf so they can also express themselves well in the sign language and writing, reducing the need for family members to act as interpreters.
- The leaders of the deaf associations should promote and encourage the deaf to go to the health facilities with their own interpreters to assist the deaf on arrival and should make them aware of their presence and notify the HCWs that they are deaf.

#### **7.4.4 Deaf-friendly health facilities**

- Sign language posters should be displayed in all consultation rooms with a few common and practical signs to show deaf people that an attempt is being made to communicate.
- Development of deaf-friendly health care-based technologies to assist the communication between HCWs and deaf patients. With the development of a deaf-friendly health care-based technology the discomfort of a sign language interpreter can be alleviated, facilitating the growth of a good relationship between the HCWs and deaf patients.
- Public hospitals should provide special cards or identifications to boost easy and fast identification of deaf patients on their visit to a health facility.

#### **7.4.5 Further research**

- A practice framework needs to be developed to promote communication between hard of hearing patients and HCWs.

### **7.5 FINAL CONCLUDING REMARKS**

The aim of the study was to explore and describe the experiences of HCWs regarding maintenance of confidentiality concerning hearing challenged people in selected public health settings in eThekweni District, KZN in South Africa. This study is another contribution to address issues related to the maintenance of confidentiality for hard of hearing patients. This study does not claim to exhaust the subject but to raise attention to new investigations in other realities. More

research in the larger representative population of HCWs and hard of hearing patients is necessary to make the health care system more accessible and communication with HCWs more satisfying and effective. A doctoral study is necessary that will develop a practice framework to facilitate communication between hard of hearing patients and HCWs.

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# APPENDICES

## Appendix 1: DUT Ethics clearance



22 July 2019

Ms S K Dlamini  
P.O. Box 1487  
Longmarket Street  
Pietermaritzburg  
3200

Dear Ms Dlamini

**Experiences of health care workers regarding maintenance of confidentiality concerning hearing challenged people in selected public health settings in eThekweni District, KwaZulu-Natal.**  
**Ethical Clearance number IREC 098/19**

The Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letters.

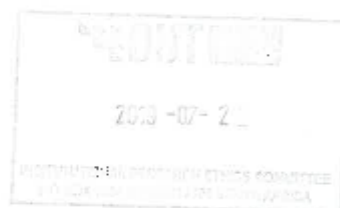
Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC Standard Operating Procedures (SOP's).

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely

Professor J K Adani  
Chairperson: IREC



**Appendix 2a: Letter of request for permission to the District Manager of eThekweni Health District**

P.O Box 1487  
Longmarkert Street  
Pietermaritzburg  
3200  
[Date]

The District Manager  
EThekweni Health District  
Mavville  
4001

---

**Request for Permission to Conduct Research**

---

Dear Dr Green

My name is Snenhlanhla Kelly Dlamini, a Master of Health Sciences student at the Durban University of Technology. The research I wish to conduct for my master's dissertation and the study title is: *Experiences of health care workers regarding maintenance of confidentiality concerning hearing challenged people in selected public health settings in eThekweni District, KwaZulu-Natal.*

I am hereby seeking your consent to collect data from the health care workers who provide services to the hard of hearing patients and are employed at Addington Hospital and Inkosi Albert Luthuli Central Hospital.

I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact my supervisor, Prof MN Sibiya, email: nokuthulas@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

---

Snenhlanhla Kelly Dlamini  
Durban University of Technology  
Email: dsnenhlanhla780@gmail.com  
Cell: 0711473394

## Appendix 2b: Approval letter from the District Manager of eThekwini Health District



**health**

Department:  
Health  
PROVINCE OF KWAZULU-NATAL

83 King Cetshwayo Highway Mayville, Durban, 4001  
Tel: 031 240 5455 Email: [www.kznhealth.gov.za](http://www.kznhealth.gov.za)

### DIRECTORATE: CORPORATE SERVICES

#### ETHEKWINI HEALTH DISTRICT OFFICE

27th June 2019

Dear Snenhlanhla Kelly Dlamini

**Re: Permission To Conduct Research at eThekwini District Facilities.**

This letter serves to confirm that your application to conduct the research study titled, “**Experiences of health care workers regarding maintenance of confidentiality concerning hearing challenged people in selected public health settings in eThekwini District, KwaZulu-Natal..**” in the eThekwini district at the following health care facilities has been recommended:

1. Addington Hospital
2. Inkosi Albert Luthuli Central Hospital

Kindly upload this letter together with your application as required to the Health Research and Knowledge Unit for the KZN Department of Health for Approval.

Please also note the following:

1. This research project should only commence after final approval by the KwaZulu-Natal Health Research and Knowledge Unit, and full ethical approval, has been granted,
2. That you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
3. All research activities must be conducted in a manner that does not interrupt clinical care at the health care facility,
4. Ensure that this office is informed before you commence your research
5. The District Office/Facility will not provide any resources for this research
6. All logistical details must be arranged with the CEO/medical manager /operational manager of the facility,
7. You will be expected to provide feedback on your findings to the District Office/Facility Yours sincerely

**Dr N Green (District Research Coordinator) Pp Ms. T. P. Msimango**  
**Chief Director (Acting) eThekwini Health District**

Fighting Disease, Fighting Poverty, Giving Hope



### Appendix 3a: Letter of request for permission to the KZN Department of Health

P.O Box 1487  
Longmarkert Street  
Pietermaritzburg  
3200  
[Date]

The Health Research and Knowledge Management Component  
KwaZulu-Natal Department of Health  
Private Bag X9051  
Pietermaritzburg  
3201

---

#### Request for Permission to Conduct Research

---

Dear Dr Lutge

My name is Snenhlanhla Kelly Dlamini, a Master of Health Sciences student at the Durban University of Technology. The research I wish to conduct for my master's dissertation and the study title is: *Experiences of health care workers regarding maintenance of confidentiality concerning hearing challenged people in selected public health settings in eThekweni District, KwaZulu-Natal.*

I am hereby seeking your consent to collect data from the health care workers who provide services to the hard of hearing patients and are employed at Addington Hospital and Inkosi Albert Luthuli Central Hospital.

I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact my supervisor, Prof MN Sibiya, email: nokuthulas@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

---

Snenhlanhla Kelly Dlamini  
Durban University of Technology  
Email: dsnenhlanhla780@gmail.com  
Cell: 0711473394

## Appendix 3b: Approval letter from the KZN Department of Health



**health**

Department:  
Health  
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langalibalele Street, Pietermaritzburg  
Postal Address: Private Bag X9051  
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782  
Email: [hrkm@kznhealth.gov.za](mailto:hrkm@kznhealth.gov.za)  
[www.kznhealth.gov.za](http://www.kznhealth.gov.za)

**DIRECTORATE:**

Health Research & Knowledge  
Management

Ref: KZ\_201907\_005

Dear Ms S Dlamini  
(DUT)

**Subject: Approval of a Research Proposal:**

1. The research proposal titled 'Experiences of health care workers regarding maintenance of confidentiality concerning hearing challenged people in selected public health settings in eThekwin District, KwaZulu-Natal.' was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

The proposal is hereby **approved** for research to be undertaken at Inkosi Albert Luthuli Central and Addington Hospitals.

2. You are requested to take note of the following:
  - a. Kindly liaise with the facility manager **BEFORE** your research begins in order to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.
  - b. Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.
  - c. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to [hrkm@kznhealth.gov.za](mailto:hrkm@kznhealth.gov.za)

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

**Dr E Lutge**

Chairperson, Health Research Committee

Date: 16/07/19

#### **Appendix 4a: Letter of request for permission to the Hospital Managers of the selected hospitals**

P.O Box 1487  
Longmarkert Street  
Pietermaritzburg  
3200  
[Date]

The Hospital Manager  
XXXX Hospital  
Durban  
4000

---

#### **Request for Permission to Conduct Research**

---

Dear Dr Ndlangisa

My name is Snenhlanhla Kelly Dlamini, a Master of Health Sciences student at the Durban University of Technology. The research I wish to conduct for my master's dissertation and the study title is: *Experiences of health care workers regarding maintenance of confidentiality concerning hearing challenged people in selected public health settings in eThekweni District, KwaZulu-Natal.*

I am hereby seeking your consent to collect data from the health care workers who are employed in your institution and are providing services to the hard of hearing patients.

I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact my supervisor, Prof MN Sibiya, email: [nokuthulas@dut.ac.za](mailto:nokuthulas@dut.ac.za)

Thank you for your time and consideration in this matter.

Yours sincerely,

---

Snenhlanhla Kelly Dlamini  
Durban University of Technology  
Email: [dsnenhlanhla780@gmail.com](mailto:dsnenhlanhla780@gmail.com)  
Cell: 0711473394

## Appendix 4b: Approval letter from the Hospital Manager of Inkosi Albert Luthuli Central Hospital



**health**

Department:  
Health  
PROVINCE OF KWAZULU-NATAL

800 Vusi Mzimela Road, Mayville, 4058  
Private Bag X03, Mayville, 4091  
Tel: 031-2401063 Fax: 031-2401050 Email: nomusa.mkhize@ialch.co.za  
www.kznhealth.gov.za

**Nursing Management**

Inkosi Albert Luthuli Central Hospital

Ms.S.K.Dlamini  
Durban University of Technology

Dear Madam

### Re-Request for Research support letter

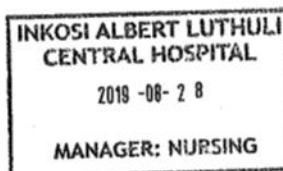
Inkosi Albert Luthuli Central hospital is hereby giving you support for your research.

Please be reminded that before you embark on your research the following documents are required:-

- Ethical Clearance from your university.
- Approval from KZN-Health Department—Research
- Approval from IALCH Gate-keeper.

Yours sincerely

N.O.Mkhize—Nurse Manager



## Appendix 4c: Approval letter from the Hospital Manager of Addington Hospital



**health**

Department:  
Health  
PROVINCE OF KWAZULU-NATAL

**ADDINGTON HOSPITAL**

P.O. BOX 977  
DURBAN  
4000  
Tel: 031-327-2970 Email: reshma.boodhai@kznhealth.gov.za  
www.kznhealth.gov.za

**OFFICE OF THE CHIEF EXECUTIVE OFFICER**

Reference: 9/2/3/R

Date: 28<sup>th</sup> June 2019

**Principal Investigator:**  
➤ **Ms SK Dlamini**

**PERMISSION TO CONDUCT RESEARCH AT ADDINGTON HOSPITAL:**  
**"EXPERIENCE OF HEALTH CARE WORKERS REGARDING MAINTENANCE OF**  
**CONFIDENTIALITY CONCERNING HEARING CHALLENGED PEOPLE IN SELECTED**  
**PUBLIC HEALTH SETTINGS IN ETHEKWINI DISTRICT, KWAZULU-NATAL"**

I have pleasure in informing you that permission has been granted to you by Addington Hospital Management to conduct the above research.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. Addington Hospital will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to Addington Hospital.

**DR M NDLANGISA**  
**HOSPITAL MANAGER**  
**ADDINGTON HOSPITAL**

## Appendix 5: Letter of information for the interview participants



Dear Participant

Thank you for agreeing to participate in this study.

**Title of the Research Study:** Experiences of health care workers regarding maintenance of confidentiality concerning hearing challenged people in selected public health settings in eThekweni District, KwaZulu-Natal.

**Principal Investigator/s/researcher:** Ms Snenhlanhla K. Dlamini, MHSc: Health Sciences Candidate.

**Co-Investigator/s/supervisor/s:** Prof M.N. Sibiya, D Tech: Nursing

**Brief Introduction and Purpose of the Study:** Communication between a health care provider and the patient is a pre-requisite for any meaningful intervention to occur in the process of seeking health care. Most deaf patients depend on interpreters when seeking health care, as they experience communication barriers with health care providers. Failure to use the interpreter can end up in miscommunication and misdiagnosis if the health care provider is not convenient with sign language. The use of an interpreter can affect ethical standards and patient's confidentiality and privacy. Health workers like nurses have the responsibility to provide health services to patients. Health care workers are tasked to ensure the delivery of information to the patient is accurate and their privacy is well kept confidential. The aim of the study is to determine health care worker's experiences regarding maintenance of confidentiality concerning hearing challenged people in eThekweni District, KZN.

**Outline of the Procedures:** You are invited to participate on a one-on-one interview that will take approximately 30-45 minutes. The interview session will be conducted at a venue, date and time that is convenient for you. I will facilitate the interview discussion. For record purposes, I kindly request to audio-record the interview discussion.

**Risks or Discomforts to the Participant:** There are no anticipated risks or discomforts for participating in this study.

**Benefits:** This study may help to improve health services delivery to the deaf people during consultations in the hospitals.

**Reason/s why the Participant May Be Withdrawn from the Study:** You may withdraw from the study at any stage if for any reason you don't want to participate anymore in the study. There will be no adverse consequences should you choose to withdraw from the study.

**Remuneration:** There is no remuneration for participating in this study.

**Costs of the Study:** You will not be required to pay any costs towards the study.

**Confidentiality:** Your name will not appear in the questionnaire and any other research documents. Codes instead of your name will appear in the research documents.

**Research-related Injury:** There is no anticipated research-related injury that is associated with this study.

**Persons to Contact in the Event of Any Problems or Queries:** Please contact the researcher on 0711 473 394, my supervisor, Prof MN Sibiya on 031-373 2704 or the Institutional Research Ethics Administrator on 031-373 2375. Complaints can be reported to the DVC: Research, Innovation and Engagement Prof S Moyo on 031-373 2577 or [moyos@dut.ac.za](mailto:moyos@dut.ac.za)

## Appendix 6: Consent



### Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Ms S.K. Dlamini about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: \_\_\_\_\_,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
<b>Full Name of Participant</b>	<b>Date</b>	<b>Time</b>	<b>Signature / Right Thumbprint</b>

I, Snenhlanhla Kelly Dlamini herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

_____	_____	_____
<b>Full Name of Researcher</b>	<b>Date</b>	<b>Signature</b>

_____	_____	_____
<b>Full Name of Witness (If applicable)</b>	<b>Date</b>	<b>Signature</b>

_____	_____	_____
<b>Full Name of Legal Guardian (If applicable)</b>	<b>Date</b>	<b>Signature</b>



## Appendix 7a: Demographic data for the interview participants

### SECTION A: PERSONAL INFORMATION

Participant No:

Date.....

Age.....

Gender.....

Race: .....

Designation.....

Years of experience in the current position.....

## **Appendix 7b: Interview guide**

### **Grand tour question**

What are your experiences regarding hard of hearing patients?

### **Probing questions**

- How do you feel working with hard of hearing patients?
- How do you communicate with hard of hearing patients?
- Which communication preferences are given to hard of hearing patients before consultations?
- When do you allow family members to interpret for hard of hearing patients during consultations?
- What information is provided to the family interpreting in terms of confidentiality?
- How do you ensure information shared during consultations is kept confidential?
- How do you ensure that patient relationship is maintained during consultation?
- What communication barriers do you experience with hard of hearing patients?
- What measures do you use to overcome the communication barriers?

## **Appendix 8: Sample of a transcript**

### **Sample of transcript**

Interviewee: Participant no.12

Interviewer: SK Dlamini

Date of interview: 28 August 2019

Place: Hospital A

Duration: 10:35

List of acronyms: IN-Interviewer, PT-Participant

(Beginning of Interview)

**IN:** Thank you for your time and participation, what are your experiences in terms of communication with hard of hearing patients sometimes deaf patients?

**PT:** *It differs there are patients some are completely deaf and some are hard of hearing, for those who are hard of hearing you have to raise your voice and secondly look them in the eyes because some even though they may not hear what you are saying they can lip read. Those who are completely deaf you also try to maintain eye contact and communicate using signs that you know, some signs we have tried to learn and some we do not know. Most of the time patients who cannot talk come with someone who can translate. In cases where the patient came alone, cannot write, cannot lip read we end up asking the patient to go home and come with someone to help translate. We write a letter for the patient to take home.*

**IN:** So, tell me how you communicate with those patients who are completely deaf:

**PT:** *.....(sigh) We try, we try our very best maintaining eye contact, writing down, raise our voices and also show that we are willing to help and pay attention, we also take notice of their facial expression to see if whatever what are trying to say they can understand or not. You can see with a smile that they can understand.*

**IN:** When the patient comes, as an HCW how do you know the type of communication the patients prefers?

**PT:** *I will greet the patient, if I see that it's an Indian or white person I say "morning" but if it's an African person I say "Sawubona" I will notice when they respond, sometimes you can see that even though they responding they speak Sesotho because sometimes patients keep quite only to find out they cannot*

*understand the language. Some do not know Isizulu totally so you try and communicate with the language they know if you can. Unfortunately, we do not know sign language so even if the patient can sign, we only depend on writing.*

**IN:** When do you involve family members or relatives that accompany the hard of hearing patients in the consultation's rooms?

**PT:** *When the patient enters the facilities and come to the nurses station we ask for whatever we need from them and let them sit, when it's time for consultation we call them together with the person accompanying because the patient needs to understand whatever that will be said inside, the doctor will communicate with the person accompanying then they will translate the information. Most of the family members with patients who are completely deaf are sign language trained.*

**IN:** What kind of information do you give the family members or the person accompanying the hard of hearing patient in terms of confidentiality?

**PT:** *The first thing we need to know that as you are accompanying the patient how are you related to them it may happen that they have been asked they are not related or part of the patients family which makes it easy for that person to go out to the community and disclose the patients information. We ask if they are part of the patient's family and if they live with them, if yes then we include them because they are the people who should know about the health to support the patient. We do not allow people who are not related to the patients. We tell them that they are not supposed to tell anyone what was discussed about the patient because they are included because they have to help the patient and remind the patient with the return dates and home care for example with tracheostomy patients.*

**IN:** How do you maintain patient confidentiality during consultations?

**PT:** *We ensure that the consultation room doors are closed, they are away from the other patients so that even when we raise our voices the other patients still cannot hear*

**IN:** We know regarding minors like children that parents are essential but in adults do to ask them if they want the person accompanying them to come in the consultation room?

**PT:** *The patients can say no, and they can wait outside but also, we consider if they do not want them inside are, we going to be able to communicate effectively with the patient without the family member. It is better when a patient can write because we can communicate through writing, but it had never happened that a patient did not want the person accompanying them not to be involved in the*

*consultation. It is usual the patient when they are called in, they would point out the person they are going with to come as well to the consultation room.*

**IN:** For people accompanying the patient do you just allow anyone that comes with the patient or certain people that usually come with the patient?

**PT:** *Most of the time, we know the people who usually accompany the patient for example, there is a patient who is a 12 years old who is completely deaf, we know that if they don't come with the father then the mother will come, so it rarely happens that we have people we do not know accompanying the patient.*

**IN:** How do you maintain the HCW-patient relationship when you have a family member accompanying the patient to interpret as the third person in the consultation room?

**PT:** *It is very difficult... I do not want to lie but because in the room we are four now, it's the doctor, the nurse, the family member and the patient. The doctor will ask the nurse, the nurse will ask the accompanying person who will ask the patient that how it goes. I cannot skip the family member and ask the patient because I cannot communicate through sign language, I can end up asking a wrong question and getting a wrong answer and giving the doctor the incorrect information. That is why when we have the Autology clinic it ends late because patients take long in the consultation because we can even spend 5 minutes dealing with one question while sometimes, they still must do procedures. However, we make sure that we keep our focus to the hard of hearing patient because sometimes they must go for operation, they have to know the reason and understand everything because they will have to sign a consent.*

**IN:** I guess it would be a good question for me to ask, how many HCWs are trained here on sign language?

**PT:** *No one is trained in this department; we teach ourselves because we always have challenges communicating with hard of hearing and deaf patients. As we become closer to the patients, we become interested. We try and get signs and learn them, but it is not enough.*

**IN:** What are the communication barriers that you face as HCWs dealing with hard of hearing patients?

**PT:** *umh...the fact that we are not trained in sign language makes it very hard for us to communicate because some patients do not come with family members so we try signing, those who can write we ask them to write, but it is quite a challenge I wish government can try and train us with sign language in the hospitals.*

**IN:** What measures do you use to overcome communication challenges?

**PT:** *We use writing; if it is a language that we are not familiar with, the hospital management sends an email around the hospital for a HCW who knows the language and they assist; but it is quite a problem because even when a volunteer comes to assist, at times, the patient cannot understand the volunteer.*

**IN:** We have come to the end of the interview. Thank you so much for your time and for participating in this research study.

(End of transcript)

## Appendix 9: Certificate from the professional editor

### **EDIT A SHAH (PTY) LTD**

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#### **EDITING CERTIFICATE**

**EXPERIENCES OF HEALTH CARE WORKERS REGARDING MAINTENANCE OF  
CONFIDENTIALITY CONCERNING HEARING CHALLENGED PEOPLE IN SELECTED PUBLIC  
HEALTH SETTINGS IN ETHEKWINI DISTRICT, KWAZULU-NATAL/Snenhlanhla Kelly Dlamini  
(21508355)**

I am a freelance editor specialising in proofreading and editing academic documents. I confirm that I have edited this dissertation and the references for clarity, language and layout. I used the track changes/review option in Microsoft Word. I returned the document to the author:

- Ensuring that spelling, grammar, punctuation, line spacing, and font is consistent and correct.
- Checking the List of References for consistency and style and checking entries against online databases to check accuracy of spelling and reference detail.
- Ensuring that all references in the text appear in the List of References and vice versa.

Resolving and accepting the changes in the text and references is the responsibility of the author.

#### **My Qualifications and Experience:**

- 30 years' experience as a research librarian at the University of KwaZulu-Natal and the Durban University of Technology.
- 16 years' experience in editing theses, research reports, teaching materials, journal articles, newsletters.
- Scribing, recording and transcriptions for workshops, seminars, debates.
- Facilitating and lecturing at Workers' College and Durban University of Technology.
- Master's in Library & Information Science, University of KwaZulu-Natal.
- B.Bibl.(Hons) in Library & Information Science, University of South Africa
- Higher Diploma in Education, University of South Africa.
- B.A. University of Durban-Westville

**Thara Devi Shah (Director)**

**06 NOVEMBER 2019**