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Interprofessional communication in a rural hospital.

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CHAPTER 1

INTRODUCTION

This research was inspired by my experiences during my community service year after graduating as a speech therapist and audiologist. Since 2003 all allied healthcare graduates are required to work a compulsory community service year before being granted independent practitioner status from the Health Professions Council of South Africa (HPCSA). As part of this year, many new graduates are placed in areas unknown to them. When applying for hospitals, like most of my peers, I chose to apply to urban hospitals only. The thought of being far from friends and family in a rural community made me nervous. During the placement process, I was not allocated any of my first 25 hospital choices and ultimately had to choose from 5 hospitals in Mpumalanga. To this day I am unsure how I selected the district hospital, a small rural hospital situated between the Mozambique and Swaziland borders. However, I feel it was one of the best decisions I could have made both personally and academically.

It was at this hospital that I was able to experience the reality of rural health care. During my year of community service I gained an understanding of what it feels like to work in an environment that is geographically isolated, a work environment with minimal supervision and scarce resources, coupled with the communication challenges that exist when working in a rural South African community. It was these experiences that motivated me to focus my research on this unique environment. Having to work and interact with a diverse team highlighted different kinds of interactions and I saw how this

influenced interprofessional communication. My experiences ranged from involvement in well organised interprofessional meetings and collaborative teamwork to high conflict interactions which often involved little or no communication with specific professions and individuals. It was these experiences that helped me to develop my research question.

As a participant observer in the setting, it was clear that my previous involvement at the research site could create potential bias, however, I feel that my previous affiliation with the site better enabled me to communicate openly with the participants as I was viewed as “one of them” and was able to understand their situation and the particular context with some depth. I must also note that despite my familiarity with the setting, the research findings have continually surprised me and were often unexpected.

Research Rationale

The health care community encompasses various professionals who are required to communicate interdependently on a daily basis in order to ensure the best care is given to their patients. The South African health care environment is represented by individuals from diverse cultures, languages, socioeconomic groups and communities. Our present Minister of Health, Dr. A Motsoaledi, at the launch of the Human Resource for Health Strategy (2011) at the University of the Witwatersrand was quoted as saying: “The health workforce can only contribute meaningfully to the improvement of health outcomes if health workers are available, competent and delivering quality service

within the set norms and standards". Current medical practice is moving towards and promoting interprofessional communication (Iedema, 2007) and studies have shown that improved communication between professionals leads to better patient care, shorter hospital stays for patients, improved planning and a greater role for health care workers (Atwal & Caldwell, 2006).

In Murphy's (1998) article on health care in South Africa he interviewed the previous Minister of Health Dr. Nkosazana Dlamini-Zuma. "South African training institutes should train South Africans for South African problems, priorities, and national needs, and this includes medical schools and teaching hospitals," she said when asked about medical training in South Africa (Murphy, 1998, pp. 1422). Despite these views, health practitioners are not traditionally taught teamwork and communication skills during their undergraduate training (Youngwerth & Twaddle, 2011). Although there is some curricular focus on these issues, the introduction of interprofessional education into health sciences degrees is fairly new (Mashingaidze, 2010). In the past, interprofessional skills were not deemed beneficial, resulting in a separation between health care workers in South Africa (Beatty, 1986). Other than separation of health care workers, deeper issues can be found between health care workers including power struggles, blurred professional boundaries and role identity crisis (Gilbert, 1998). Consequently, many graduates start working in the health care environment without these valuable skills.

Research about rural facilities and cultural issues in health care is crucial as there is an acknowledged link between health, illness and culture (Tjale, 2004). There is a growing trend in health care fields to view the patient beyond their illness and to adopt a more holistic transcultural treatment approach. This is important not only for patient care but for improved interaction and communication between health professionals.

Speech and language therapists are communication experts and therefore could play a greater role in the development of team communication. South Africa's policy of community service for all health care professionals means that more professionals are being placed in rural settings and speech and language therapists in these positions have an obligation to use their skills to aid patient care and provide training to staff/ team members if needed. Community service speech and language therapists and audiologists have reported that they experience many challenges in the health care setting including difficulty collaborating with other professionals, diverse caseloads, no interpreting services, lack of resources and equipment, minimal supervision and an observed need for role expansion (Penn, Mupawose & Stein, 2009).

Health care professionals face many challenges working in rural settings. Staff often have limited resources and funding, minimal staff due to a high turnover of posts, little or no specialised services (e.g. neurology) and operate within a third world environment (Bateman, 2012) . Staff in the rural setting report having higher levels of stress and fewer support systems than their peers working in urban environments (Delobelle, et al.,

2010). The importance of effective health communication is increasingly being recognised in health care globally. The Health Communication Research Unit at the University of the Witwatersrand have completed numerous research projects across South Africa and has identified many unique challenges of living and working in South Africa. Challenges include high patient caseloads, huge burden of disease, especially HIV/AIDS and TB, shortage of staff and resources, language barriers, emigration of professionals, traditional healers and cultural beliefs (Barratt, 2004; Barratt & Penn, 2009; Evans, 2001; Penn, Mupawose & Stein, 2009; Penn, Watermeyer & Evans, 2011).

Research is needed in South Africa to understand interprofessional communication, especially in rural areas. This research is highly relevant as there is little understanding of rural interprofessional communication and minimal research in this field. For improved services in rural areas, one needs to have an understanding of the community and how they perceive health care and how these individuals interact within their environment. The study may be able to influence practice and policy and has some implications for education. Therefore, this study explores how interprofessionals communicate in the rural setting and how communication is perceived, in order for services and training to be tailored to varied community situations. The South African health care system is moving towards universal coverage with the implementation of National Health Insurance (NHI). This study comes at a critical time where primary health facilities are in the process of change and this research has the potential to

create a local model of interprofessional communication, which could be expanded at a National level.

South African context

South Africa has an estimated population of over 50 million people, 31.3% of which are under the age of 15 years. In South Africa, it is estimated that over 5 million are infected with HIV, with a prevalence rate of 10.6% (Statistics South Africa, 2011). Further, it is estimated that 16.6% of the adult population between the ages of 15-49 years is HIV positive and 43.6% of deaths in South Africa are HIV-related (Statistics South Africa, 2011).

The South African health care system cannot be separated from the discrimination experienced in the past. Apartheid policies separated people of different races in all facets, including health care, education, service delivery, employment and housing. In 1990 it was reported that only 5.5% of doctors worked in rural areas and minimal funding was provided for health care in these areas (Bell, 2006). South Africa still faces many challenges with poor service delivery in all sectors. Barriers experienced in South African health care include the high burden of disease, poor supervision, language and cultural barriers, emigration, social and geographic isolation in rural areas, staff shortages, staff attitudes and perceptions, lack of equipment, high poverty and violent crimes (Barratt, 2004; Barratt & Penn, 2009; Daviaud & Chopra, 2008; Evans, 2001; Penn, Mupawose & Stein, 2009; Penn, Watermeyer & Evans, 2011).

Post democracy in 1994, the health care system has faced new challenges: the HIV epidemic, weak management, poor leadership and a human resources crisis (Coovadia, et al., 2009; Daviaud & Chopra, 2007). Rural areas have been hardest hit by inadequate staffing and poor distribution of staff. Mpumalanga, the location of the research site, has only 21 doctors per 100 000 people who access public health care services (The Presidency, 2008). While South African policies have been praised for their innovation, many have been inadequately implemented impacting on their success. South Africa is viewed as a middle-income country but statistics show it has worse health outcomes than countries with lower incomes, as evidenced by the increase in child mortality (Coovadia, et al., 2009).

South Africa is in the midst of a staffing crisis and has seen a decline in optimal health care professional to patient ratios because vast numbers of health care professionals are moving into the private sector or immigrating (Coovadia, et al., 2009). A South African study, which examined staffing requirements in primary health care facilities (Daviaud & Chopra, 2007), showed extreme shortages of health care professionals, especially doctors. Staff were unevenly distributed and only 30% of admin posts were filled. The study highlights the difficulty of providing quality health care in rural South Africa due to various challenges.

Patients who access public health care systems face many hurdles like socio-economic, cultural and linguistic barriers. Further in the South African context other barriers to health care have been identified, such as poor adherence to medication, late presentation at clinics and hospitals, use of traditional medication and a high rate of communicable diseases (Levin, 2008). Communication between patient and health professional, and even between health professional and health professional, can require the use of an interpreter or cultural broker. Language barriers affect certainty and flow of information, work productivity, attitudes, and quality of care and can lead to ethical dilemmas (Schlemmer & Mash, 2006). In the hospital setting, there are few interpreters and nurses are commonly used as substitute interpreters, which can cause frustration over roles and duties, affecting work satisfaction (Pfaff & Couper, 2009). Many medical professionals frequently use untrained interpreters, calling into question not only the reliability of the translation but also the confidentiality and trust within the interaction (Penn & Watermeyer, 2012). Untrained interpreters, with insufficient language skills, used in the medical field run the risk of communicating ineffectively resulting in possible translation errors (Levin, 2008).

South African research is influenced by our unique environment; this can be seen in our health care. Nursing studies show a high level of dissatisfaction in the public sector (Delobelle, et al., 2010; Pillay, 2009). In both sectors, nurses are dissatisfied with their pay, large workload and lack of resources (Pillay, 2009). Nurses in both sectors did however express high levels of satisfaction with their patient interaction, relationships with other professionals and their role in the community. In the Delobelle et al. (2010)

study, half of the nurses surveyed reported the possibility of changing jobs in the next two years, with three out of ten nurses expressing a desire to emigrate.

Research in the South African context has examined community service for health care professionals and the impact of a rural setting on the community service practitioner. Rural community service professionals have expressed that they feel they had less supervision, less opportunity for training and development and greater language issues than their urban peers (Reid, 2002). Community service was created to alleviate the lack of health professionals working in government, particularly in rural health posts. However in 1999, only 25% of health professionals were placed rurally. Furthermore there is a significant trend of rural origin doctors not returning to their community to practice (de Vries & Reid, 2003; Reid, 2002). While the majority of community service workers described their year as “positive” and beneficial, past research shows that up to 43% of community service doctors reported that they would like to emigrate overseas (Reid, 2002). Emigration is a huge challenge facing South Africa with many health care workers across all fields choosing to emigrate due to the unique challenges that face the South African health care system (Penn, Mupawose & Stein, 2009; Reid, 2002).

A recent article on rural rehabilitation identified challenges faced in the Eastern Cape, KwaZulu Natal and Mpumalanga (Bateman, 2012). Staff reported difficulty working in the rural environment due to limited budgets, lack of supervision, high staff turnover, difficulty referring patients, short hospital stays for patients leading to reduced rehab

services, misuse and mismanagement of human resources, unclear protocols, poor motivation and insufficient skills of staff members among others issues (Bateman, 2012). Other challenges included difficulty referring children to the Department of Education and an insufficient number of special education schools to cater to the needs of the community (Bateman, 2012). Two articles have been published on rural speech, language and hearing therapists in the Mpumalanga province. The articles discuss the challenges faced in their rural rehabilitation unit from lack of resources, inadequate infrastructure, poverty, lack of training of staff, lack of community awareness of services available and an imbalance between staff at a hospital and a clinic level (McKenzie, 1992; Schneider, 1992).

The South African health system is currently under reform with the implementation of the pilot National Health Insurance (NHI) scheme in 2012. NHI aims to provide universal health coverage for all South Africans. The new system seeks to alleviate the current health crisis that is challenged by high HIV/AIDS and other communicable disease rates, socio-economic discrepancies and staff shortages (NHI, 2012). South Africa currently has two health systems, the public and the private sector. The Green Paper on the NHI suggests the merging of the public and private health care systems to provide greater health care access to all (Van Heever, 2011). The NHI further sets out to even the discrepancies between the two health care systems with the richest 40% of the population enjoying nearly 60% of the benefits, while the poorest 40% of the population have access to only one fifth of the benefits (Ataguba & McIntyre, 2009). A South African study looked at the shortage of health care workers and further suggested that

health care workers need to be trained with skills and expertises that complement the needs in the public health sector (George, et al., 2012).

Mpumalanga

Mpumalanga is 76 495 square kilometres in size, making it the second smallest province covering only 6.3% of South Africa (Statistics SA, 2010). Mpumalanga has the fourth highest per capita income in South Africa with numerous industries including farming, mining, tourism and plantations (Delius & Hay, 2009). In 2011, the population of Mpumalanga was 3 657 181, constituting just over 7% of the South African population (Statistics South Africa, 2011).

The most common age of death in 2007 was between 30-34 years, which is linked to Mpumalanga's high incidence of HIV and HIV-related diseases. South Africa's socio-political climate is affected by its high rate of violent crime. The world average of murders per population of 100 000 is 8.8, Africa's average is 22.2, and South Africa has an alarming rate of 42.7, with Mpumalanga having the highest levels of murder, robbery and rape in the country (Higson-Smith, et al., 2005).

In Mpumalanga, 92% of the population is black, 6.8% is white and 0.8% and 0.4% of the population are coloured and Indian/Asian. While the majority of the population speak SiSwati (29.4 %), other African languages are spoken too, and these include isiZulu

(24.1%), Tsonga (11.6%), Ndebele (10.3%) and Northern Sotho (10.2%). In the more urban areas of the province, Afrikaans or English are spoken predominately. Furthermore, Mpumalanga has less urban development compared to other provinces in South Africa, with 65% of the population living rurally (Higson-Smith, et al., 2005). The main priorities in the rural areas of Mpumalanga are basic needs such as housing, water, sanitation, roads, education, health and employment (Koma, 2010; Judson, 2001; Ntsebeza, 2006). It is reported that 91.3% of households in Mpumalanga have access to water, however only 42.6% have flush toilets and 8.2% have no toilet facilities at all (Statistics South Africa, 2007). Mpumalanga has had little development in education since 1994 with 10% of the population having no schooling and only 18% of the current population having completed grade 12.

The research setting

The Nkomazi district, where the hospital research site is located, is a predominately rural area. Previous research has been conducted in this area looking at caregivers' experiences of caring for a cerebral palsy child (Barratt, 2006), disability narratives (Barratt, current study), HIV testing and health seeking behaviours (Eche, 2011). Barratt (2006) describes the area surrounding the hospital as one that is highly affected by poverty, HIV and traditional beliefs and practices. The large area has only two primary health care hospitals and 25.7% of the population have no formal education and 24% are illiterate, other important indicators are discussed in table 1.

Table 1: A breakdown of Nkomazi's socio-economic indicators (CRDP, 2012)

Demographic & health	• Population of 334 668 in 2001 has increased to 390 610 in 2011 • Youth up to 34 years make up 75.5% of Nkomazi population • HIV prevalence rate among antenatal clients tested in 2010 was 47.3% which was the highest rate in Mpumalanga.

Labour	• Unemployment rate of 34.3% (2011) which is the lowest rate in Mpumalanga.
	• Leading employment sectors
	  ○ Community services (27.2%)
	  ○ Agriculture (21.2%)
	  ○ Trade (17.5%)

Education	• Nkomazi has the highest rate (in Mpumalanga) of individuals who have no schooling, 25.7% of the population. • However it has the highest (in Mpumalanga) Matric pass rate of 76.2%. • Functional literacy rates improved from 40.9% in 2001 to 67.6% in 2011.
Basic service delivery	• 2.9% of households are informal dwellings • 15.9% of households have no toilets or live with the bucket system • 81.5% of households have access to piped water • 83.3% of households have access to electricity for lighting • 20.3% of households receive weekly municipal refuse removal
Development	• The Nkomazi district has a poverty rate of 61.4% indicating that 224 685 people in Nkomazi live in poverty.
Economy	• Economic growth rate of 0.3% for 1996-2011 and 2.5% forecast for 2011-2016 which is the second lowest in the province • Nkomazi's contribution to the Mpumalanga economy is only 1.8%

The majority of the population are SiSwati speakers with Tsonga and isiZulu as second and third languages. Less than 15% of Nkomazi residents have running water inside their residences and approximately 30% travel to collect water from a central point. The Nkomazi population has risen in the past few years with the youth making up over 75% of the population. The Nkomazi District has a poverty rate of 61.4% and is influenced by the high levels of unemployment.

Conclusion

This chapter has provided the rationale for the study as well as the researcher's personal experiences that have shaped the research question. The understanding of the South African context is crucial for this study and is a precursor to understanding rural health care factors in South Africa. The setting of this research is in an impoverished area that is known for having high unemployment, high HIV and other communicable diseases and poor education.

CHAPTER 2

COMMUNICATION IN HOSPITALS

Overview

This chapter examines recent literature on communication specifically in the medical setting. The chapter will highlight the importance of communication in the health care environment as well as various themes, findings, methods and implications. Communication research in the South African context as well as studies focusing on rural health care will be explored.

Communication in Health Care

Communication is a vital part of everyday life. The need for effective communication increases in a work environment, like a hospital, where communication is both social and functional. Effective communication channels rely on the sender and receiver, as well as the accurate interpretation of the message (Parry, 2004). In a hospital setting it is fundamental that the message between communicators is interpreted correctly for successful patient management and a happy working environment. Communication interpretation is influenced by the person's social background, culture, group identity, perceptions, gender, cultural world view, language, values, attitudes and prejudice (du Pre, 2000).

Communication has four main functions (Crafford, 2009). It can be used to share information between individuals or with groups, to express emotional feelings as well as to motivate and finally communication can be used to control behaviour. The direction of communication is important because it identifies the flow of information. The direction of communication can be downwards, upwards or lateral. Downwards communication happens when information is passed from a higher level to a lower level, whereas upwards communication happens when feedback travels from the lower groups up to top management. Lateral communication takes place when individuals or groups share information with others who are on the same hierarchical level as themselves (Craffold, 2009).

Communication within any organisation relies on three different methods. The first method is oral communication which is the most popular form. Here information is passed verbally either with formal presentations or meetings or by informal conversations. The advantages of this method are that it is quick and allows for instant feedback by the listener. However if the message has to travel through a number of sources first it has the potential to become distorted. The next method of communication is written communication, which is any type of information which is written down such as newsletters, memos, files, emails and so on. This method is useful as it can be verified and the information on the document can be stored indefinitely. The last method of communication is nonverbal communication. Nonverbal communication is when individuals communication by nonverbal means using body language, intonation, facial expression and physical distance. These cues are unreliable as they

are not concrete and they have to be interpreted by the listener who may misinterpret the information (Craffold, 2009).

A team is a group of individuals who actively engage with each other to achieve a desired goal (du Pre, 2000). In the health care setting, health care workers communicate and interact on a daily basis to provide services to patients. Teamwork has many advantages for health care workers and patients as it reduces costs, provides multiple perspectives and aids in providing biopsychosocial health care. However teamwork can also lead to conflict and competition between health care workers and is time consuming (du Pre, 2000). Teams and groups differ in their structure and function. Groups share information to obtain a common goal, yet accountability is usually individual and skills can be random and varied. Teams, in comparison, need to collectively work together to reach their set goal. Accountability is individual and collective and the skill set within a team is usually complementary (Mendes & Stander, 2011).

Communication within teams is influenced by interpersonal and systemic factors. The World Health Organisation released a *Team Building* document in 2007 to address common issues related to team work. This document acknowledges the importance of interpersonal and external systemic influences as they indirectly affect the success of the team. Interpersonal issues that negatively impacted on team dynamics and communication were inadequate support, poor goal setting and communication,

unresolved interprofessional conflict, poor understanding of other team members' roles and unclear leadership. Systemic factors that were identified as barriers to teamwork included excessive workload, lack of external support, lack of resources and inconsistent working environment. Teamwork, is directly affected by the members that make up the team yet in the South African context the staffing crisis across all professionals undoubtable will influence interactions and communication in teams. However there appear to be no current studies that have looked at the interpersonal and systemic factors affecting teamwork in the rural South African health care context, therefore it is unknown whether they may be influenced by similar challenges or even additional context specific challenges.

Communication in South African Health Care

As discussed in chapter 1, South Africa faces many challenges in the health care setting. Health communication research aims to understand communication in the health care environment as once challenges or issues have been identified, there is the potential for intervention (Lagerwerf, Boer & Wasserman, 2009).

An important study to acknowledge is Watermeyer's (2012) research which looked at factors which contributed to successful care at an HIV clinic in South Africa. The study found that organisational routines were beneficial for health care workers as it helped with staff identity as roles and responsibilities were defined. Organisational routines were further noted as improving work efficiency. Staff in the clinic were encouraged to

rotate tasks to gain experience and understanding of various activities. Another factor accredited to the clinics success was good interprofessional teamwork which staff attributed to friendship, trust, support and understanding between team members. The study further noted that the corridor conversations between patients and health care workers was found to be beneficial as the communication occurred in a neutral space and aided in building relationships.

The majority of health communication in South Africa focuses on communication between health care workers and their patients. There has been little research on interprofessional interactions and communication in the South African context. One study that did address this issue was Gilbert's (1999) study that examined the interprofessional role of pharmacists and nurses. This qualitative study used interviews, surveys and reviews of published reports and found that social and historical contexts affected pharmacists in this study. This is a crucial result as it acknowledges the importance of the context in which this research is based. An anthropological study was conducted in the Eastern Cape, South Africa focusing on health communication problems that occur due to the multicultural South Africa setting. This study used the qualitative methods of observations and interviews in a rural hospital (Herselman, 1996). The study found multiple barriers to communication in the rural health context including socio-cultural differences between doctors and patients, language issues, defensiveness among patients and psychosocial factors. The findings of this study included a section on issues specifically related to communication. Common communication issues included lack of understanding, inability of patients to label a

condition and submissiveness in patients when interacting with doctors. This study further confirmed the importance of context on health research in South Africa.

Another important South African study that examines the role of communication, context and culture in health care looked at patient adherence to HIV/AIDS medication and the role of the pharmacist (Penn, Watermeyer & Evans, 2011). The study made use of numerous methods of data collection including observations, interviews and focus groups at four different research sites. The study found that understanding contextual and interactional factors directly impacted on the success of treatment. Other findings of the study were the importance of qualitative methods in understanding barriers in diverse multicultural health care environments.

International research on communication in hospitals

Numerous studies have looked at the hospital environment, interprofessional interactions, doctor-patient interactions and communication. In this section I will discuss different areas of communication in hospitals as well as specific focuses such as handover, health care workers and teamwork.

Communication is central in the process of handover. Good handover is beneficial for both patients and health care workers as good handover has been found to improve patient care and satisfaction, reduce medical error and provide health care workers with

additional peer support (Jorm, White & Kaneen, 2009). Observations on handover in four different Australian Hospitals by Solet et al. (2005) identified barriers and recommendations for handover. The study found four main barriers when doctors were observed giving handover. The barriers included language issues, physical setting, social setting and medium of communication. The study noted that language barriers affect the quality of information being passed on with medical terminology being last in translation.

The medium of communication, as discussed early in this chapter, was essential to the amount and type of information given. Direct verbal handover provided clearer information than indirect means like files or phone calls. The most interesting barriers were those connected to the setting. The study noted the significance of the physical environment aiding handover communication. An environment with high levels of background noise, frequent interruptions and poor lighting were unfavourable when providing handover. Similarly the social setting was important for health care workers as they felt they were able to share more information in a comfortable relaxed environment (Solet, et al., 2005). Other studies identified handover as a ritualistic activity that would influence the type of communication between health care workers (Strange, 1996; Lally, 1999).

Health care workers, especially those working in the rural environment often face additional workplace challenges. Rural health care workers have reported experiencing

barriers to accessing information, isolation, lack of resources, lack of skills training and limited means to connect with the outside world, for example no internet access (Dorsch, 2000). Although some of these barriers are experienced in urban areas they are more prominent in the rural setting. Rural hospitals and clinics have higher turnover of health care workers and this may be due to professionals not having adequate training to deal with rural issues (Chipp, et al., 2011). While health care workers acknowledge that their work is rewarding, the challenging environment can often lead to burnout.

Burnout is a condition caused by high levels of stress in the working environment. Burnout appears as exhaustion with negative attitudes to work peers, professional identity and emotional exhaustion. A study by Keshvari (2012) found that rural health care workers reported 6 themes associated with stress and challenging work conditions. These included instability and frequent changes, unbalanced workload, helplessness to perform tasks, threatened professional identity and deprivation of professional development.

Other rural health challenges mentioned in the literature included building communication channels between the medical facilities and the community. Researchers found that the community were sceptical of the health care workers and did not trust hospitals due to previous experiences and issues regarding confidentiality. Handover can be more challenging in a rural context as there can be blurred

professional and social boundaries and limited anonymity due to small professional circles.

Health care workers reported difficulty in maintaining previous lifestyles due to geographical isolation and this affected their self-care practises (Alan, Ball & Alston, 2008; Chipp, et al., 2011). Rural health care sites both internationally and within South Africa rely on foreign health care workers. These workers have additional challenges as they are expected to understand the local culture and other staff and the community often have high expectations (Dywili, et al., 2008).

There is a vast amount of literature on health care workers and teamwork. Team approaches vary according to organisations or department's needs. A recent study found that interprofessional team work is more successful than multidisciplinary teamwork in medical rehabilitation (Korner, 2010). The study reported that interprofessional teamwork was found to be more effective; however the study had a relatively small sample size and did not consider other health care departments. Team characteristics have also been found to influence the success or failure of a team (Mickan & Rodger, 2005). Positive characteristics included well defined boundaries and objectives, common interests, shared ownership and good conflict resolution skills.

Health care teams have been found to have complex needs. Teams are required to make quality decisions, however the process behind those decisions are more complicated in a health care environment. Before a team decision can be made information needs to be collected and processed. All team members need to communicate and all need to be valued within the team. The information then needs to be diplomatically discussed and collaboration is then required to make a decision (Propp, et al., 2010). Similarly team cohesion and synergy needs to be kept up by creating a positive work environment, having mentorship programmes, managing conflict and advocating for all professions. Furthermore health care team interactions are complex because they require diverse expertise (Solheim, McElmurry & Kim, 2007).

A literature review using qualitative and quantitative research on teamwork in the primary health care setting found two main themes in the literature that influenced the success of teamwork. The first theme was team structure which included the team environment, the team size and the support structures available to the team. Familiarity and well-structured environments supported hospital teamwork. Further smaller teams were found to be more successful than their larger counter parts as they were able to communicate more effectively with a smaller group. The second theme to emerge was team processes which looked at the frequency of meetings, setting goals and evaluating performances. The study concluded that interprofessional team work was found to be highly beneficial in primary health care facilities where goal setting was part of the agenda and where good leadership was present (Xyrichis & Lowton, 2008).

Interprofessional Communication

Interprofessional collaborative practice has been defined as a process that includes communication and decision-making, and enables synergistic influence of grouped knowledge and skills (Bridges, et al., 2011). *"Interprofessional working refers to interactions between team members, whereas multiprofessional or multidisciplinary working refers more readily to a group of people who come from different health and social care professions but who do not necessarily interact"* (Atwal & Caldwell, 2006, pp. 359).

Interprofessional communication does not only refer to the communication between professionals but includes, and is influenced by, numerous factors. Power dynamics are common in the health care setting as professionals may view themselves as superior or inferior to our professionals (Earle & Letherby, 2008). Hierarchical management and professional systems often contribute to the power struggle where doctors are viewed as the professional, while other consulting professionals are seen as 'paraprofessionals' (Friedson, 2008). This power imbalance can alter one's perception of other healthcare professionals or of a specific individual (Oliver & Keeping, 2010). There are a number of elements involved in interprofessional collaboration in the health care setting, namely: responsibility, accountability, coordination, communication, cooperation, assertiveness, autonomy, mutual trust and respect (Kenward, 2011).

The most recent interprofessional communication studies have been done in the field of nursing, with one of the most common research sites being the Intensive Care Unit (ICU) (Havens, et al, 2010; Rose 2011). The majority of interprofessional research has been conducted in Canada, America, England and Australia. Nurses' communication with other health professionals has been studied and further research examines the impact that this may have on patients. The research found that for communication to be successful, three precursors need to be established. These include: shared goals, shared knowledge and mutual respect. These three factors need to function simultaneously with the communication being timely, frequent, accurate and appropriate for problem solving (Havens, et al, 2010).

Other common themes that have emerged from interprofessional interaction research include power and power sharing, blaming language, the use of silence, stereotyping and lack of understanding of other health professionals' role in the team (Hean, et al., 2006; Gardezi, et al., 2009; Havens, et al., 2010; Brown, et al., 2011; Kenward, 2011; Rose, 2011). It was also found that professionals who used problem solving communication over "blaming language" had better coordination of services because information between professionals was shared rather than withheld due to fear of blame (Havens, et al, 2010).

Silence plays a role in communication between health professionals and has been found to play three different roles: lack of communication, not responding to a request

and speaking quietly (Gardezi, et al., 2009). The researchers from this study also discovered that the use of silence was often strategic or defensive in response to the participants' environment. Other notable findings include the role of power, influences of the institution and the situation that the participant was working in. While conflict in a working environment is often inevitable, good interprofessional management and education can solve many of the disputes. A 2011 study in the UK found that conflict in the work environment was often caused by unclear work boundaries and scope of practice, as well as lack of recognition (Brown, et al., 2011).

Gardezi et al.'s (2009) study includes common examples of communication breakdown in the hospital setting, which include ignoring a request, failure to ask for clarification, failure to speak loud enough for all to hear and failure to communicate or refer to the appropriate person. A Canadian study by Rice, Zwarenstein, Conn, Kenaszchuk, Russell and Reeves (2010) completed an intervention to improve interprofessional collaboration and communication. The intervention programme involved health care professionals introducing themselves to their colleagues and explaining their role in the hospital. Participants were then invited to discuss issues related to interprofessional interaction. Finally, participants gave interaction specific feedback. The programme's success was evaluated using comparative qualitative methods: ethnography and interviews. The test group was then compared to a control group that had not completed the programme. They found that while support for the project was strong initially, there was minimal support from senior staff. The intervention was poorly explained to junior staff and was poorly modelled by the senior staff (Rice, et al, 2010). This study

demonstrates a resistance to change and that intervention needs to be done at a deeper level to change senior therapists' perceptions and habits.

Health care in South Africa is based on biomedical principles that co-exist with traditional medical practices (Tjale, 2004). Eighty-percent of South Africans will seek out medical opinions from traditional healers and sangomas (Ross & Deverell, 2004; Baleta, 1998). With growing Western ideals many are choosing to consult with both Western and traditional medical practitioners, thus blurring medical boundaries. Culture is central to medicine: not only do health practitioners have to understand their patients' culture but also that of their colleagues (Kleinman & Benson, 2006). Education about other cultures, especially the cultures of our colleagues, is important as it impacts on a person's thinking, problem solving and behaviour. This breakdown in communication can lead to emotional and physical stress, as well as segregation of the individual (Allwood, 1985).

Interprofessional education in South Africa

Providing quality primary health care in South Africa requires the involvement of numerous health care staff, as well as an active involvement of the community. To achieve quality of care, a number of competencies and issues need to be addressed like transparency and communication. One solution that is being posed to address this issue is early interprofessional education in South Africa (El Ansari & Phillips, 2001; Reid, 2011). Young, Baker, Waller, Hodgson & Moor's (2007) study examined medical

education and interprofessional exposure amongst third year medical students. Ninety-one percent of the participants reported clinical benefit from interprofessional activity, confirming the relevance of receiving training during tertiary education. The study acknowledged that collaborative skills were not innate and needed to be taught and cultivated. The learning of interprofessional skills for the third year students was found to be more successful when shown practically and within the hospital context.

Interprofessional education should be included as part of the health care curriculum as it aids students in recognising their personal identity and allows them to gain an understanding of how to interact with other professionals and the roles of other professionals (Bridges, et al., 2011). Students not only need to be taught the importance of but also need to see the benefits of interprofessional collaboration in action. Multicultural awareness in education will allow for practitioners to view cultural diversity as an asset and not a handicap (Tjallinks, 2004). This has particular relevance in a rural setting as rural health care is know to have addition challenges. A student who has been exposed to rural health care and interprofessional training may be better equipped to cope in a challenging environment.

Interprofessional communication and management

While it is important for health professionals to recognise interprofessional collaboration, management plays a key role in the support and administration of such collaboration. Managers however often have little understanding of the different roles of health care

practitioners. In some cases, staff felt conflicted between their professional responsibilities and the instructions given by management (Mills, et al., 2010). A Policy on Quality in Health Care for South Africa (DOH, 2007) was released by the South African Department of Health in 2007. The document discusses numerous issues, including interventions aimed at health care professionals, training, professional development and the district team. The policy acknowledges the importance of training and continuing professional development of all health care professionals (DOH, 2007). While the document does mention communication and provides suggestions like translating information and providing timeous information, it does not mention interprofessional collaboration of teamwork.

Interprofessionalism and Speech-Language Therapy in South Africa

A study completed at the University of the Witwatersrand by Penn, Mupawose and Stein (2009) looked at feedback given by community service speech and hearing therapists. While community service was first established in South Africa for doctors in 1998, it only became compulsory for many other health professionals in 2003. The basic premise of community service was to increase the distribution of services, however only 25% of eligible doctors are placed in a district setting (Daviaud & Chopra, 2007). In Penn et al's study, during feedback sessions, many issues were raised by the graduates including: ethical issues, management and interprofessional challenges. All of the graduates acknowledged the value of interprofessional collaboration. Participants noted that community service holds value because it provides insight into working with other

professionals and the role of other professionals. They commented on the benefit of teamwork and noted occasionally experiencing tension between other professionals due to poor definition of work roles and boundaries.

From this literature review three factors are clearly evident. The first is that qualitative methods such as observations, interviews and focus groups appear to be the most successful when studying a phenomenon like communication in health care. The second feature to emerge from this literature review is the importance of context when studying health communication. Clearly the unique socio-political context of South African hospitals has an impact on health care workers and patterns of communication. The third aspect to consider from this review is the significance of understanding communication processes in the health care setting. From reviewing this literature it appears my research is well positioned to add insight into this developing field. No research has been conducted on interprofessional communication with such a diverse sample nor has there been research of this nature within the rural South African health care context.

Conclusion

Successful interprofessional communication has been found to improve the quality of medical services. Literature has shown that interprofessional work is beneficial to both the health care professional and the patient. International interprofessional research has illustrated the barriers to interprofessional communication in the health setting. The South African context provides a unique and complex environment to discuss such

issues such as staff shortages, the burden of HIV/AIDS, high levels of emigration of professionals, poor supervision, language and cultural barriers, social and geographic isolation in rural areas, staff attitudes and perceptions, lack of equipment, poverty and violent crime.

Good communication in a working relationship implies that there are shared goals, shared knowledge and mutual respect. Furthermore, communication needs to be timely, accurate and frequent. There is little research on understanding communication challenges between health care professionals in South Africa and almost no research on interprofessional communication in a rural hospital setting. This study is well positioned within a crucial time in South African health care. The findings of this study may provide important themes which could be used to create training programmes, influence policies and aid in understanding an area in which limited research has been done.

CHAPTER 3

THEORETICAL FRAMEWORK

Overview

In this chapter, I will describe Goffman's model of impression management and dramatic theory and its potential to be applied successfully to the rural healthcare setting. This chapter further examines Goffman's front and backstage model and how this model may be beneficial for understanding communication in a rural health care setting. The Eco-social theory is discussed as an additional framework to complement Goffman's theory and to aid in identifying systemic influences in the rural environment. These two theories complement each other in that that allow for analysis of both micro and macro feature that may be found in the data.

Social Interaction Theory

Social interaction theory is a broad framework that examines how perceived meanings are developed by social actions and institutions (McDonnell, et al., 2009). The main basis for this theory is that society can be examined by focusing on micro-interactions that occur daily between individuals. *"Human beings are believed to themselves create or develop the rules and normative practises within their culture rather than merely responding to the dicates of social structure"* (McDonnell, et al., 2009, pp. 64). Humans are viewed as active participants who have the ability to shape their environment. The

theory suggests that change comes from a bottom-up perspective as social processes are viewed at the level of the individual.

Under the umbrella of social interaction theory there are numerous extensions of the theory. Two of these extensions are symbolic interactionism and ethnomethodology. Symbolic interactionism theory is based on the thought that an individual's action is determined by the symbolic meaning they attach to themselves (McDonnell, et al., 2009). Therefore the individual understands his/her world by interpreting their own and others' actions and attaching meaning to the action. In this way the individual is actively creating social norms in their context. Ethnomethodology examines the actions of an individual and how individuals classify actions according to processes and methods, by examining micro-level social interactions and macro structures (McDonnell, et al., 2009). This framework is important to researchers as it allows them to study the health care setting at the interaction level in order to better understanding the individual in the health care setting. Goffman's work has been found to be highly relevant when studying any health care environment (Lewin & Reeves, 2011; Murphy, 2009; Tanner & Timmans, 2000).

Goffman's Dramaturgical Model & Impression Management

Erving Goffman in his work *'The Presentation of Self in Everyday Life'* explains his dramaturgical model that analyze and examines social interactions in relation to the theatre. Goffman's dramaturgical work looks at interaction according to front stage and

backstage principles. The front stage is where an individual projects the image he or she wishes to present to the public (McNeil, 1989). Backstage is what occurs off scene and is less formal and structured, often providing a more realistic understanding of the individual. Goffman coined the term impression management, which describes when a group or individual act or behave in a specific manner to create or maintain an image of themselves (Gardner & Martinki, 1988). Impression management is an important concept for leaders and managers as they can use their behaviour to positively influence their organisation as well as their staff. Impression management first emerged in Goffman's 1959 book *The Presentation of Self in Everyday Life*.

In impression management the actor manipulates the social setting, appearance and interactions in order to convey a good self-impression. The appearance of an individual expresses and confirms an image and is particularly important for first impressions and for identifying with a specific group. In this study the social setting is contained within the hospital. Health professionals would use different social settings based on their job requirements. A nurses' main social setting for example might be in the ward while an administrative clerk would be in an office.

Goffman not only looks at the 'actor', but extends his analysis to the setting and props. Props are an important tool as they can be used to convey membership of status (Murphy, 2009; McNeil, 1989). In the health care settings individuals may use props which further portray their desired image or status. Typical props used by staff in a

hospital include stethoscopes, patient files and medicine whereas a white coat may be used to indicate the status of a doctor or associate and identify them within a profession specific group.

Figure 1: A model of potential stage areas that might occur in a hospital using Sinclair's (1997) adaption of Goffman's front and backstage

	Official	**Unofficial**		
Front Stage	✓ Morning meetings ✓ General formal meetings ✓ Multidisciplinary meetings	Hospital events: o Educational talks o Training o Functions	**Lay world**	**Off Stage** ▪ Family time ▪ Church ▪ Weekends & holidays
Back Stage	✓ Patient files ✓ Phone calls ✓ Impromptu/corridor conversations ✓ Tea room	o Dinner with other health care professionals o Socializing – restaurants/ bars		

Sinclair (1997) later modified Goffman's front and backstage and included two additional levels (See Figure 1). Sinclair found this model useful to understand the teaching

environment when studying the habits of medical students. In Sinclair's model he adapted the front and backstage to include an *official* and *unofficial* area where interactions took place. By adding the additional *official* and *unofficial* areas he was able to better classify and understand his observations.

Lewin and Reeves (2011) in their study on interprofessional communication between medical staff in a hospital in the UK further modified Goffman's front and backstage model. They used the terms *planned* and *unplanned* to classify different interactions and types of communication in the front and backstage (See Figure 2). For the purpose of this study, this modified framework was chosen over the Sinclair model as the planned and unplanned levels were often determined by types of communication and added to the focus of this research. It should be noted that Lewin and Reeves did not include the lay world in their model. In this study eco-social theory will be used to explore elements of the lay world that are noted by participants. Eco-social theory will be discussed later in this chapter.

Planned front stage is an area where hospital staff interacts in a planned and structure manner. *Unplanned front stage* still takes place in front of an audience but it is less formal in nature due to its unstructured interaction. *Planned backstage* is an interaction that occurs in a private space yet due to the nature of the activity being planned the language is still formal, however staff would be able to discuss issues and challenges

freely. Finally, in *unplanned backstage* interactions, communication is opportunistic in nature with little or no formality.

Figure 2: A model of potential stage areas that might occur in a hospital using Lewin & Reeves's (2011) adaption of Goffman's front and backstage

	Planned	**Unplanned**
Front Stage	✓ Ward ✓ Casualty ✓ Out-patients department	o Multi-disciplinary meetings o Departmental meetings o Phone calls o Files
Back Stage	✓ Impromptu/corridor conversations ✓ Theatre ✓ Office	o Nurses station o Tea room o Lunch area

Front stage is the area where hospital staff members can express their desired self, confirm status and hierarchy and display their power. Individual's interactions have been found to be formal in nature and are more restrained. In contrast the backstage may not reflect the image that the individual wishes to portray. The atmosphere in this space is

more relaxed and the individual and group can use the backstage to rehearse or prepare for front stage interactions.

The majority of literature that examines teams only focus on their front stage communication and has not considered the importance and complexity of interprofessional interactions that take place backstage. As shown in chapter 2, communication in the health care setting is a crucial part of any health care workers routine (du Pre, 2000). The demand on communication increases in the health care environment when teams are required to work in an interprofessional fashion to accomplish common goals.

Lewin and Reeves (2011) successfully used Goffman's impression management to examine interprofessional teams working in a hospital ward. Their study found that impression management, particularly Goffman's front and backstage, was useful in identifying interactions in the hospital ward and that their stages indicated the need for interprofessional intervention to be targeted at both a front and backstage. Murphy's (2007) study focused on using impression management to understand complex interactions between radiographers and their patients. This qualitative study found the method of front and backstage helpful in analysing rituals and patterns that occurred. Backstage interactions were the focus of Tanner and Timmons' (2000) study that looked at backstage communication in a hospital theatre. This qualitative study used detailed observations and applied Goffman's dramaturgical model. The researchers found that

the model was successful in the analyses of a health care institution but that in a health care setting it did not always take into consideration time constraints within the environment (Tanner & Timmons, 2000).

Health care studies using Goffman's impression management and dramaturgical model have found the framework to be helpful in understanding the interactions and types of communication being observed or reported. All of these studies reviewed were found to be of a qualitative nature with the primary source of data collected being ethnographic observations (Lewin & Reeves, 2011; Murphy, 2007; Tanner & Timmans, 2000; Wittenberg-Lyles, et al., 2009).

To gain a realistic and complete understanding of how professionals communicate one has to acknowledge both formal and informal communications that take place. Lewin and Reeves (2011) found minimal interprofessional collaboration between professionals. Many of these professionals felt that they were working within interprofessional groups yet the majority of their interactions were parallel in nature and not collaborative. Especially during ritualistic tasks, teams in their study worked in the same space but did not often have common goals. Lewin and Reeves (2011) study further confirmed the importance of the backstage in health care interactions.

Other medical studies which used Goffman's front and backstage have noted the importance of backstage for professionals to express their emotions and maintain their

professional image, the importance of private space for hospital staff and the role of rituals in front stage interactions (Murphy, 2007; Somerset, Weiss & Fahey, 2001; Tanner & Timmans, 2000; Wittenberg-Lyles, et al, 2009). Allowing health care workers a backstage space to deal with and express emotions was found to be important to allow the health care worker to maintain their front stage identity (Wittenberg-Lyles, et al, 2009). Private backstage space further allowed for health professionals to interact informally and without additional work stressors which allowed for different working relationships to develop on a more equal level and blurred professional boundaries that were present in the front stage (Tanner & Timmons, 2000).

Goffman's theories of impression management and his dramaturgical model focus on interpersonal influences that affect communication but these theories do not account for systemic influences other than to label them as lay world factors. To understand these systemic factors a broad framework of eco-social theory will be applied. Figure 3 shows possible systemic factors that may influence a health care worker. It is important not only to look at the micro-interactions that occur within the health care setting but also to include the systemic influences which may impact the individual and the environment, and in turn affect communication.

Goffman's theories of impression management and dramaturgical models have been used in this research as they offer a unique perspective on interactions between health care professionals, further the front and backstage models provide insight into the often

unexplored interactions that are crucial in the development of relationships between professionals. It appears that Goffman's framework, from previous medical literature, is usual in the medical setting in identifying unique areas in which different types of communication may take place. Understanding where important communication is transferred in the rural South Africa medical setting would be helpful as the information could be used to improve communication and assist in effective training programmes.

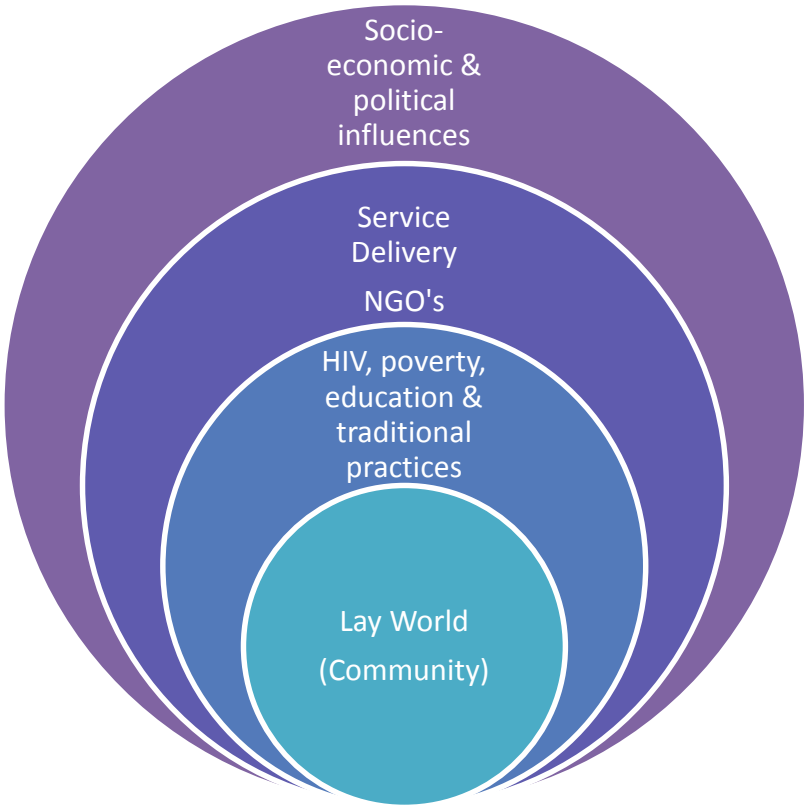
Eco-social Theory

Eco-social theory comprises of both the individual and the contextual system in which they function in (McLaren & Hawe, 2005). It examines the activities, adaptations and behaviours within a specific setting while exploring the impact that context and community have on the individual. This model recognises the importance of social, political and economical factors which shape the environment and the individual (Krieger, 2001). This multi-level framework was made famous by Bronfenbrenner's ecological systems theory which focused on the interrelationship between processes and their environmental context (Darling, 2007).

In chapter 2 the literature describes communication in health care and acknowledged how fragile interprofessional communication is and how it can be affected by interpersonal and systemic influences, however with the unique South African context discussed in chapter 1 it is unknown how these influences affect communication in a rural hospital. This study will therefore apply Goffman's framework to see if it is affective

in understanding interprofessional communication at a rural hospital at a micro level however the macro level will make use of the eco-social theories use of interpersonal and systemic categories.

Figure 3: Possible lay world/ external factors which may influence the health care worker



Due to the context of this research the systemic influence of the rural environment is a factor to consider when examining interprofessional communication in this hospital setting. While systemic factors other than the rural setting of the hospital are not the

focus of this study, any systemic factors observed or discussed during interviews or focus groups will be explored further in the results. To further aid the understanding of the emerging themes, the results will be categorised according to systemic and interpersonal findings. By separating the results into these two categories the influences of rural health context can be better understood.

Conclusion

Applying Goffman's framework, the present study is therefore designed to explore front and backstage interactions in a rural South African hospital and the factors that influence communication in these spaces. Previous studies stress the importance of backstage communication to provide support and a safe environment to express oneself. This study demonstrates how this crucial role appears to be even more valuable in the rural setting where professionals may have the burden of additional stress factors. Based on an analysis of the theory it appears that it has the potential to explain many features of communication interactions in the health care setting. The question obviously remains as to whether this framework will assist in understanding and explaining communication in the unique rural context.

CHAPTER 4

METHODOLOGY

Overview

This chapter describes the methods used in this research project. The chapter examines the design of the study, the research aims, the research setting, participants, data collection and analysis and any ethical considerations. This chapter further looks at specific elements that were used in the data collection, such as vignettes.

Research aims

The aim of this research project is to describe and understand communication between health care professionals working in a hospital situation in a rural context.

Objectives

- To gain an understanding of the interpersonal and systemic factors that influence health care workers working in a rural health care setting.
- To examine which factors influence communication in a rural health care setting.
- To explore whether the theoretical framework of dramaturgical theory has some relevance in describing and explaining interprofessional communication in a South African rural hospital.

Research design

- **Qualitative research**

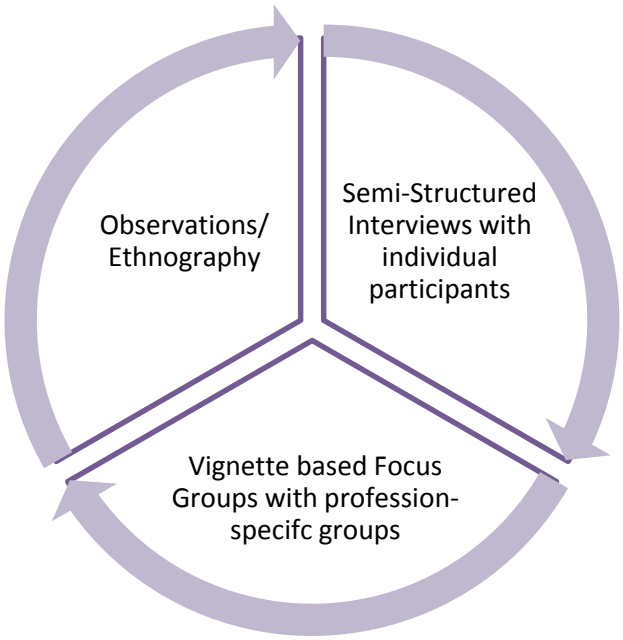
A qualitative research design was used for this study. I selected a qualitative research framework as it has the potential to capture some of the complexities of communication in the health care setting. As discussed in chapter 2, qualitative research methods have been found to be successful in study communication in various health care settings. A qualitative design was chosen as it allows for in-depth descriptions of a specific phenomena being studied (Meline, 2007). Further, it allowed for the participants to share more personal information, experiences and feelings, which are crucial for understanding how communication affects the individual.

Qualitative research is valuable as a means of research, especially in health care as medicine is now being recognised as more than just the application of scientific rules, numbers and statistics. While exploring participants' experiences may on the surface appear anecdotal and circumstantial it has however been found to be more influential in the change and understanding of clinical practice (Green & Britten, 1998; May, 1996). This is especially helpful in the medical field to identify barriers to healthcare. Qualitative research describes a phenomenon, offers an understanding and gives insight into real world interactions and helps to determine recommendations to improve practice (Emden, et al., 2001). Qualitative research has been found to be particularly useful in understanding perceptions and needs in health care contexts across diverse cultural populations and different languages (Penn & Watermeyer, 2012; Penn & Evans, 2009; Twinn, 1997).

- **Data collection**

Data were collected using several methods that allowed for triangulation. These methods included multiple profession-specific focus groups (doctors, nurses, allied and administrative staff) and individual interviews with each participant, as well as detailed observations in the hospital context. These methods have been found to be useful when studying rural health care sites in South Africa (Barratt, 2006; Evans, 2001). This study used Patton's (1999) triangulation of methods. By using different data collection methods the consistency of the results can be checked.

Figure 4: Data Collection Methods



Data collection included:

1. Semi-structured interviews using a question guideline consisting of open ended interview questions and probing questions that could be used to elicit more detailed responses (See Appendix 12-13).
2. Focus Groups – focus groups were run using profession-specific vignettes to guide and structure the group responses (See Appendix 8-11).
3. Ethnography - detailed observation of the hospital environment and how the participants interact within the environment.

Both interviews and focus groups were conducted to allow for more sensitive or private issues to be explored where necessary. Focus groups were conducted first so that sensitive issues and experiences could be probed further during interviews. Focus groups were profession-specific to further create an open, sensitive environment and in hindsight proved beneficial especially when themes like blame and responsibility were discussed.

Interviews and focus groups were recorded using two audio-recorders that allowed for ease of transcription after the data were recorded. Permission was gained from the participants to record information during interviews and focus groups and they were given the option to decline recordings (Appendix 7). Only the group of pharmacists chose not to be recorded. In that case the researcher took detailed notes of the participants' responses. During the observations, meetings, focus groups and interviews the researcher made detailed notes of any important observations. Semi-

structured interview questions were used during the interviews and the researcher used open ended questions to elicit more information from participants. Focus group discussions were guided with the use of a case study vignette.

- **Research assistant**

A research assistant acted as an interpreter and facilitator during the interviews and focus groups and later as a translator when transcribing data. The reason for this was two-fold: firstly, to aid with any language issues that arose and secondly to reduce any bias the researcher may have. All participants in the study were given the option to use English or siSwati during interviews and focus groups. Even though the majority of the participants' home language was siSwati, only eight interviews and four focus groups were conducted in siSwati. The research assistant was from the research area and had assisted in multiple research projects over the past six months prior to data collection. The assistant had been trained by the Health Communication Research Unit and was sensitive to the demographic culture and language of the research area. A profile of the research assistant is included in Appendix 14.

After each interview or focus group the researcher and the research assistant discussed key points and themes. Once all data had been translated and transcribed the researcher and the research assistant meet again to analyse the data together and compare notes. It is important to note that the data was further checked by the researcher's supervisors as a third party source.

Pilot study

A pilot study was conducted at the hospital with the permission of management from 23-25 January, 2011. The pilot study was conducted to test the interview and focus group vignette approaches. The response from staff was positive as all the participants were eager to talk about the subject matter and appeared enthusiastic about the research. Three interviews were conducted with a doctor, a nurse and a therapist. In addition to this, one focus group was conducted with four nurses. The data collected for the pilot study was not used in this research.

The greatest challenge during the pilot study was finding a set time for the focus group, as the focus groups needed to be conducted during working hours and staff were often called away. The researcher was able to overcome this by approaching the staff members directly after ward rounds when the wards were quiet. During the focus group there was a large amount of background noise and it was often difficult to hear participants, and this was taken into consideration when conducting interviews and focus groups for the main research. During the focus group it was noticed that the focus group vignette/case study was too long, thus these were shorted and modified. The focus group asked for the case study to be repeated and parts had to be repeated throughout the discussion, this was noted and during the focus groups the researcher made an effort to repeat and rephrase the case studies and questions.

Research setting

As mentioned in the introduction chapter of this study, this research was conducted at a hospital in the Nkomazi district of Mpumalanga, where the district hospital is located. Barratt (2006) describes the area surrounding the hospital as one that is highly affected by poverty, HIV and unemployment. People living in the area hold strong traditional beliefs. The Nkomazi Spatial Development Framework (2003) describes Nkomazi as an area of extreme poverty. This large area has only two primary health care hospitals; 32% of the population have no formal education and 24% are illiterate. The majority of the population are SiSwati speakers with Tsonga and isiZulu as second and third languages.

The district hospital opened in 1998 to aid a nearby hospital and to serve the surrounding communities. It has 152 beds with the capacity to increase to 250 beds. The hospital currently has 6 functioning wards (male, female, female surgery, circumcision, paediatrics, and nursery), an OPD (outpatient department), X-Ray department and rehabilitation department. The hospital does have an ICU ward, however it has never been used due to insufficient staffing.

Participants

An attempt was made to include a large sample in the study that was representative of the majority of the hospital staff. This study included 52 interviews (Table 2) and 12 focus groups (Table 3). A wide representation of staff was used to gain a reliable and

realistic understanding of communication in all hospital departments. The initial proposed sample size was between 30-40 participants however data was collected until saturation was reached.

The participant inclusion criteria were as follows:

1. The participant must have worked at the hospital a minimum of three months. Rural hospitals have a high staff turnover, therefore if the participants have been working at the hospital for at least three months it is assumed they would have had adequate exposure to the hospital and the hospital culture.
2. The participant must be registered as an employee of the hospital.
3. In addition, participants who are health professionals at the hospital must be registered with the Health Professions Council of South Africa.

Gender, marital status, religion, education level and income were factors that were not controlled for in this study.

Table 1 and Table 2 show a breakdown of participants in this study according to profession. The sample in this study was made up of health professionals at the hospital and included the following: doctors, nurses, clinical associates, social workers, pharmacists, dieticians, physiotherapists, occupational therapists, speech and language therapists, audiologists and admin staff. Focus groups were run in profession-specific groups as these groups were most likely to communicate with each other on a daily basis and focus groups could be run during their weekly meeting times. Profession-

specific groups were further used to reduce any conflict that may have arisen during the discussion in the focus groups between different professions.

Table 2: Health care workers who participated in the interviews

Health Professionals	Number of participants
Management staff:	2
Medical staff:	
Doctors	6
Clinical associates (students)	2
Nurses	11
Allied staff:	
Physiotherapists	3
Occupational therapists	4
Speech therapists & audiologists	1
Dietician	1
Dentist	1
Radiology staff	3
Pharmacy	3
Rehabilitation Assistant	1
Administrative staff:	
Human resources	3
Stores	4
General	1
Support staff:	
Laboratory	1
Mortuary	3
Transport	1
Kitchen	1
Total Interviews	**52**

Table 3: Health care workers who participated in the focus groups

Table of health professionals focus groups	
Health Professionals	**Number of Participants**
1. Nurse group 1	4 participants, all female
2. Nurse group 2	4 participants, all female
3. Human resources	4 participants, 3 males & 1 female
4. Stores	5 participants, 2 males & 3 females
5. Rehabilitation	6 participants, 6 females
6. Pharmacy	3 participants, 3 females
7. Mortuary	3 participants, all male
8. Maintenance	4 participants, 3 males & 1 female
9. Doctors & clinical associates	15 participants, 13 males & 2 females
10. Cleaners	4 participants, 2 males & 2 females
11. Radiology	5 participants, 2 males & 3 females
12. Administration	2 participants, all females
Total participants in focus groups	59 participants (28 males & 31 females)

Purposive sampling was used to obtain participants. The goal of effective sampling is to gain information about the target population and generalise the information gained to the remaining hospital population (Meline, 2007). Purposive sampling is often used in qualitative studies; participants are selected systematically to achieve a specific objective determined by the researcher (Teddlie & Yu, 2007). Purposive sampling was used as it is beneficial for studying people, organisations and culture and allows the researcher to choose participants based on the information and insight they could provide. The type of purposive sampling used in this study was maximum variation sampling. Maximum variation sampling collects data from a large variety of sources to describe themes that emerge across the sample (Patton, 2002). In this research multiple small samples of diverse groups were used, yielding descriptive data that enabled the identification of common themes. The large sample size ensured that data

saturation was reached and further allowed for numerous health care professionals' viewpoints and experiences with communication in a rural context to be explored.

Table 4: Languages spoken by interviewed participants (n=52)

Language	Number of participants who were fluent in each language
English	51
siSwati	44
isiZulu	35
Xitsonga	20
Shangaan	13
Afrikaans	13
isiXhosa	10
Sesotho	8
Tswana	7
Sepedi	4
Tshivenda	2
Dutch	2
Other	2

The most common language that participants were fluent in was English (Table 4), which was surprising as it was the first language of only six participants. The majority of staff were able to speak English, but the most common spoken language at the hospital is siSwati. The average number of languages spoken by a participant was four, with some participants reporting speaking seven to eight languages fluently. Eighty-three percent of participants were black, with the majority of participants (79%) reporting that they came from rural backgrounds. This highlights the diversity of cultures, traditions and backgrounds of participants. Most of the urban participants were either doctors or therapists.

Ethnography

Ethnography is naturalistic and descriptive in nature and allows the researcher to understand the participants' perceived views (Silverman, 2008). Ethnography involves observing interactions and behaviours in a specific environment, as well as taking note of the objects, props, artefacts and outputs generated (Pope, 2005). Ethnography has been used in numerous fields and in medical research for over 50 years. Ethnography was traditionally used to examine social behaviour in the field of anthropology and sociology (Button, 2000). Ethnography is beneficial because it can lead to reflection, training and opportunities for feedback (Pope, 2005). Hospitals lend themselves to ethnography as they have their own society and internal culture (van der Geest & Finkler, 2004).

Ethnography was conducted at the hospital site and around the local community and allowed the researcher to gain an understanding of cultural aspects, as well as the interactions of health care workers in various departments. The role of the researcher in the environment will affect the success of the ethnography. The researcher played the role of the "participant-observer" as she had previously been an employee at the hospital and was recognised by hospital staff members as such. Direct observation methods were conducted over two weeks. This involved detailed observation of the participants and their environment without the intrusion of the researcher. However, in the hospital setting it is difficult to be an unobtrusive observer as the researcher needs to be an "insider" and "outsider" simultaneously (Wind, 2008). The researcher in a hospital setting can take on the following roles if observations are to be naturalistic:

either the researcher can play the role of staff, patient or visitor (van der Geest & Finkler, 2004). The researcher played the role of staff/professional as this allowed a better comprehension of the professional and suited the researcher's previous identity at the hospital.

During the researcher's time at the hospital detailed notes were made about five areas in the hospital: theatre, ward, Out Patients Department (OPD), rehabilitation and administration building. These five areas were chosen as they were considered high traffic areas for staff, where interactions and communication was most likely to occur. The five areas also included the majority of participants at any one time.

During the observations the researcher made notes regarding:

- Interactions & communication
- Physical environment and props
- Staff present
- Researcher's insights, feelings & opinions

Photograph 1: Entrance to the hospital



Photograph 2, 3 & 4: Hospital spaces



Photographs 1-4 illustrate the hospitals geometric space while the photographs 5-7 in chapter 5, depict the hospitals social space. The conventional definition of space is the

geometric dimensions however, researchers are now looking at how space influence individuals and how the experience of space can be valuable in the health care environment (Kearns & Joseph, 1993).

Critical Incident

A critical incident describes an observed event or a ‘snap shot’ of a specific time and place (Martin & Mitchell, 2001), and provides insight into interactions and behaviours that occur in the research environment. Critical incidences were used in this study to illustrate and highlight theme results. The critical incidences were observed by the researcher who made detailed notes throughout the observation. A critical incident method is beneficial in the health care setting as it is a rare, interesting or task-specific incident that can be described and analysed. This technique has been used successfully, particularly in qualitative nursing studies.

Critical incidents in medical research identifies key interactions that illustrates behaviours or communication in a specific environment. These events are then described in detail to aid in understanding themes that have emerged. These incidents usually involve a ‘turning point’ which can include conflict, change of events or the introduction of a new element in the environment.

Interviews

Interviews are common as part of qualitative research because they provide a means of exploring an individual's opinions and experiences regarding a specific subject (Broom, 2005). Interviews provide more in-depth and specific information than questionnaires as the interviewer can guide, focus and expand on the conversation. They provide a personal and confidential environment where information can flow freely. Semi-structured interview questions were chosen to allow for flexibility (Broom, 2005), and the researcher was able to probe further into the information shared by the participants.

Interviews were conducted with each participant in the study, with 52 interviews conducted in total. There were two different interview guidelines, one for health care professionals and one for health care administrative staff, the only difference being that the administrative staff were not asked questions related to health care and health care interactions. The interviews began with introducing the researcher and research assistant and introducing the research topic. Interview questions were designed to obtain data about the participants' roles in the hospital, as well as their perceptions and opinions about communication in the hospital. Additional probing questions were used when necessary. The interviewer led the interviews and guided the topics and made use of open-ended questions. The length of the interviews ranged between five to 30 minutes long. The average interview length was 15 minutes. While this is considered a short interview the health care setting limited the amount of time that health care professionals could spend with the researcher and the large number of interviews

conducted helped reduced any affect that this may have had on the research. However the length of the interviews did not appear to impact on the quality of the data in the interviews.

The interview questions were informed by the researcher's previous experiences of working in the hospital, the pilot study, as well as a review of relevant literature about interprofessional communication (Herselman, 1996; Jorm, White & Kaneen, 2009; Penn, Watermeyer & Evans, 2011; Watermeyer, 2012). Questions were derived from an appreciation of the literature compiled in chapter 2 and framed using theory from chapter 3. Interview questions (Appendix 12-13) began with personal questions such as languages spoken, length of time in profession and personal cultural beliefs. Participants were then asked to share their experiences of communication in the hospital and asked to illustrate their answers with personal stories. During the interviews participants were not discouraged from naming or implicating specific people however no specific names or departments were used in the research unless it was generalised. Interviews were collected until saturation was reached.

Focus groups

Twelve profession-specific focus groups were conducted at the research site. The focus groups ran for an average of 25 minutes. Again due to the time constraints of the professionals, the focus groups did not exceed half an hour. Focus groups allowed for the participants to discuss and problem-solve issues (Flick, 2002) related to teamwork

and communication. The number of focus groups needed in a study differs from researcher to researcher, with the general guidelines being a minimum of three and a maximum of twelve to avoid redundancy (McLafferty, 2004). The size of the focus group is debateable; however, most authors suggest an average of four to 12 participants to allow for all participants to interact in the discussion and to cater to the time constraints of both the researcher and the participants (McLafferty, 2004). The number of participants in the focus group ranged from 3-15 participants. The reason for the one large focus group of 15, is that the focus group was run during the doctors meeting as it was the only available time for participants to meet.

Vignettes

"Vignettes are partial descriptions of life situations used in research and education as a strategy to elicit participants' attitudes, judgments, beliefs, knowledge, opinions or decisions" (Brauer et al., 2009, pp. 1938). The vignettes were written by the researcher and based on the researchers' personal experiences or observations. They comprised of common hospital interactions and include various health professionals and an example of a communication breakdown. Focus group questions were then based on the vignette (Appendix 8-11). For example, the vignette for the doctors' focus group is centred on a doctor relying on a nurse for interpretation, but the doctor is not sure that s/he is receiving all of the information. Each group was then asked what they thought of the situation as well as how they would change it if they were in the same position.

Multiple profession-specific focus groups were conducted (nursing staff, doctors and rehabilitation staff) until data saturation level was reached (Table 1 & 2). This method allowed for rich data collection and created greater transferability of the collected data (Patton, 2002). Each focus group discussion focused on a profession-specific vignette. The uses of vignettes are twofold. Firstly, they are used within research to help gain an understanding of a person or group's attitudes, perceptions and beliefs within a scenario (Brauer et al., 2009). In this research the scenario was based around an example of interprofessional communication. Secondly, they can be used as an effective learning tool. Vignettes can be used to examine and explore ethical dilemmas and teach problem solving skills, while also producing practical solutions (McCarron & Stewart, 2011). They can be used in the training and education of staff in a number of settings.

Participants in a study may give answers that are socially desirable; vignettes can help to overcome this by reducing the bias effect (Hughes & Huby, 2002). This happens because the participant is not answering as themselves but rather through the vignette character. One of the most important functions of a vignette is to distance the participant from the subject manner. In this way information is desensitised, avoiding potential harm to the participant, helping to build a better rapport and increasing trust during an interview. Participants within the study may feel uneasy and judged when questioned about their actions and those of others; however, the use of a vignette removes aspects of blame and accusation. Due to the sensitivity of interpersonal work relations and participants 'possible fear of judgement by management, it was decided to use vignettes in this study.

Additional Notes

The researcher utilised a quiet room to minimise noise and allow for privacy. However, due to the importance of the participants' work and the need to avoid disruption to patient care, participants were allowed to answer phone calls and leave the interview to return at a later date. During data collection no emergency phone calls interrupted sessions causing participants to leave, however, a few phone calls were noted and the audio recorders were paused during this time. Furthermore, the researcher planned interviews and focus groups during quieter periods of the day (i.e. early morning, late afternoon) or on quieter days (theatre days vs. OPD).

Ethical considerations

Ethics approval was obtained from the University of the Witwatersrand HREC medical ethics research committee (Appendix 1) and the Mpumalanga Department of Health (Appendix 2). Written permission was obtained from the hospital's medical manager (Appendix 3).

- **Obtaining informed consent**

Written informed consent was gathered by the researcher from each individual participating in the study and a separate form was signed to give consent for participants to be audio-recorded (Appendix 6 + 7). A written information sheet was given to the hospital to inform them of the research and their responsibilities (Appendix

4). An English written information sheet was provided to participants and this was also discussed verbally prior to the focus group and interview (Appendix 5). By presenting the information about the study verbally, the participants were able to ask questions about things they did not understand and the information could be presented in their home language. The researcher was then able to rephrase information that was not understood and thus ensure that consent was informed. The informed consent process was conducted in the participant's first language or a language of high proficiency to ensure understanding. “Special care is needed for participants from different ethnic, cultural, and socioeconomic groups to avoid misunderstandings based on different values and beliefs” (Meline, 2007, pp. 31). During informed consent, the participants were told the purpose of the study and the activities that they were participating in. Participants were given the right to withdraw from the study at any time with no repercussions and they were given a copy of the consent sheet that they had signed as well as the information sheet.

- **Confidentiality & Anonymity**

The information gathered during the course of the study is privileged information and will only be shared with the researchers and quotes have been anonymised. Anonymity was ensured to participants by referring to them by a randomised set of numbers or letters. Participants were informed that any information that they provided during the focus groups was done so within a group setting and confidentiality could not be guaranteed. To reduce this risk, confidentiality was discussed with the focus groups prior to any discussion. Group rules were established at the beginning of the session

and participants were informed that they did not have to answer any question that they did not feel comfortable answering. Furthermore, participants were assured that their answers would not be fed directly to management.

1.8 Data analysis

During the data collection period the researcher made numerous notes on staff interaction and daily activities in the hospital. The notes from the observations were written up as a “thick” description. A thick description is a detailed account of observations that allow the reader to understand the environment in which the research was conducted (Patton, 2002). Notes were focused around interactions, communication observed, physical layout of the hospital context and the insights and responses of the researcher.

After the completion of data collection, the researcher and research assistant spent two months transcribing and analysing data from the recorded interviews, focus groups and observation notes. Data were transcribed and data that was collected in SiSwati was translated into English for ease of analysis. It is important to note that data was translated and transcribed directly from siSwati to English, therefore some illustrative quotes may appear ungrammatically correct due to language differences. It was decided to keep the transcripts in their original state to avoid distorting the data set.

As previously mentioned, there are many challenges with translation and transcription. All of the interviews and focus groups were transcribed by the researcher and research

assistant. The data were transcribed verbatim and data collected in SiSwati was transcribed in both SiSwati and English. A speech therapist with previous experience of transcription checked for reliability between the English recordings and written transcriptions. The researcher and the research assistant checked the reliability of the siSwati transcriptions. To ensure the quality of the transcriptions and gain an understanding of the setting in which the focus groups and interviews occurred, the researcher made notes during these sessions. Notes were then analysed with the focus groups and interviews. The researcher made note of facial expressions, increases or change in tone and any changes or manipulations of the environment. This served to add additional information such as non-verbal behaviours, facial expressions and the impact of the environment.

Data was analysed with the aid of the researcher's supervisors to increase credibility, dependability and confirmability (Temple & Young, 2004, Muller & Damico, 2002, Bucholtz, 2000). Data analysis was qualitative, according to the nature of the study. Analysis included examining information collected from the direct observations, semi-structured interviews and focus groups. Information from the interviews, observations and focus groups were then unpacked and triangulated using thematic analysis (Braun & Clarke, 2006; Meline, 2007). The researcher reduced transcription error by transcribing the English data and having a research assistant check the transcriptions with the original data. Data that was collected in siSwati was transcribed by the research assistant and all transcripts were discussed and analysed together with the researcher.

Thematic analysis

Thematic analysis (TA) focuses on identifying themes and patterns in the behaviour that the researcher observes and records. TA allows the researcher to organise and describe data, as well as identify specific strong themes or quotes from a relatively large data set (Braun & Clarke, 2006).

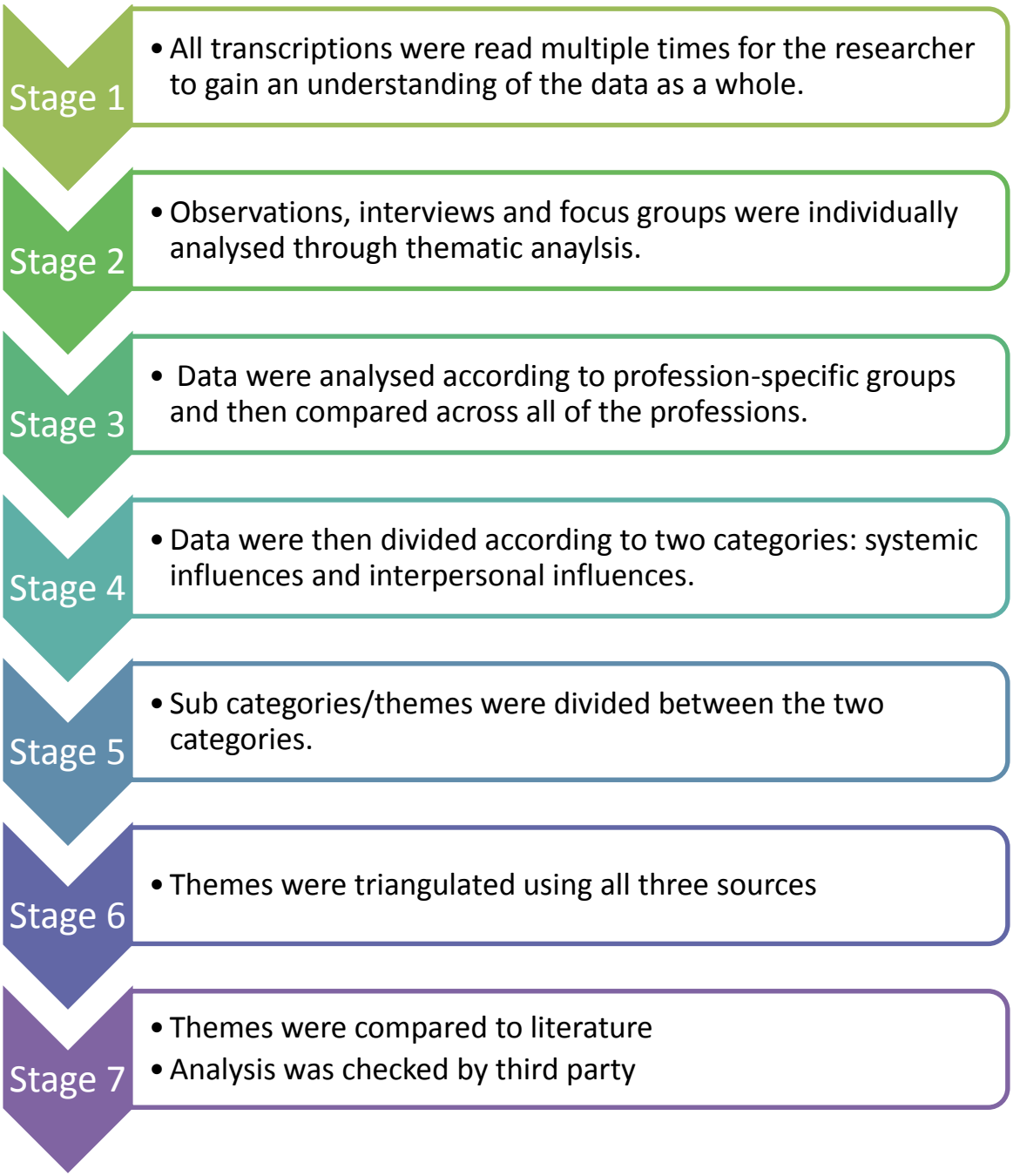
According to Braun and Clarke (2006) there are six phases when conducting thematic analysis. This includes familiarising yourself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing a report.

In line with Braun and Clarke's (2006) suggestions all data were read thoroughly by the researcher and notes were made of common themes and patterns. Themes were initially derived from individual professions and then compared across all the groups. Only themes that emerged across all professions, that were uniquely rural or that linked with literature were then categorised. Themes were categorised into two main groups namely systemic and interpersonal. Data was then linked to themes, and patterns between participants were established. Themes were then supported by the relevant data, literature and theory. By analysing the themes, a better understanding of the participants' perceptions of communication in the hospital emerged.

Data was further analysed by exploring Goffman's theory of impression management and his dramaturgical approach, this framework was discussed in chapter 3. A modified version (Lewin & Reeves, 2011) of Goffman's front and backstage was used to help classify the stage in which the interactions occurred. Goffman's model was further explored in the discussion section of this research. The data was then analysed according to front and backstage and the typical communication and interactions seen in the different stages.

The researcher read and re-read the data numerous times to get a sense of the data set as a whole. The researcher then analyzed each transcript individually according to method and profession-specific groups. Data was then compared across all methods and profession-specific groups to determine themes. Themes derived from the data set were then placed under the appropriate category. Themes were triangulated and checked for reliability. The analysis was checked by an objective third party who was not involved in the study as well has being peer reviewed by the researcher's supervisors.

Figure 5: Stages of analysis



Methods used to ensure rigour and quality

"Rigour is the striving for excellence in research through the use of discipline, scrupulous adherence to detail and strict accuracy" (Burns & Grove, 2005, p. 750). Rigour is crucial in qualitative research to ensure the quality of the study. In qualitative research rigour is the standard that researchers strive for so that their data may be presented in a succinct and understandable manner. To establish rigour in this research, the researcher followed Long & Johnson's (2002) guidelines. The researcher made use of a reflective journal and self-description of the research process, member checks were used with the participants and the researcher took part in extensive observations. The research in addition made use of peer review, triangulation, an audit trail and decision trail.

Dependability in this study was achieved by having a large sample size and using an external source to check the accuracy of the transcription and translations. To aid dependability during the interviews and focus groups, semi-structured questions were developed (Long & Johnson, 2000; Flick, 2002) and the researcher probed interesting areas of discussion further. The researcher applied the principles of dependability by using pre-set semi-structured questions, by ensuring the integrity of issues during focus groups and interviews and by having a researcher and a research assistant observe some of the interviews and focus groups.

Confirmability is the adequacy with which the data is recorded and reported (Sharts-Hopko, 2002). To aid confirmability, careful records were kept of the research process

from data collection to final analysis via a field journal. Transferability is the ability to accurately portray the participants' shared experiences (Malterud, 2001; Sharts-Hopko, 2002). This was obtained by using various methods of data. The credibility of this study was first piloted using focus group and interview questions with selected hospital staff.

To maintain rigour during the analysis process, the researcher analysed all data and matched the analysis with the data and theory. Numerous notes were taken and recordings were made providing reliable and accurate information about the different populations. Further, the research assistant aided in reducing possible bias the researcher may have had from previously working in the research environment by providing an objective view on the interviews and focus groups. All data collected was analysed and discussed with supervisors to allow for richer interpretation (Fouche, 2005). Reflexivity of the research is how the researcher has been influenced by his or her previous experiences and beliefs (Malterud, 2001). The researcher was influenced by her time working at the hospital, however this has provided her with a unique understanding of the environment, as well as a pre-established trust relationship with the participants. The researcher has reflected on her own potential bias and how this may have impacted on the research and data analysis.

Data triangulation involves the gathering of data from multiple sources for the same study. Triangulation provides the researcher with unique information, which allows for a more enriched and diverse view of the environment, the participants and the events that are being studied (Burns & Grove, 2005). Triangulation further provides a means of

validating information that has been collected (Fouche, 2005). Triangulation provides the researcher with unique information, which allows for a more enriched and diverse view and provides a means of authenticating information that has been collected. This method allows for greater consistency of data and increases research credibility (Patton, 2002).

Feedback

Four months after data collection was completed, written anonymised feedback was given to the hospital. The feedback was sent to the medical manager and the CEO of the hospital. The feedback mentioned broad themes that emerged across all professions. More detailed feedback was given to the hospital in December 2013 when the researcher returned to the site. Verbal feedback was given to management as well as the individual participants. .

Conclusion

This methodology chapter outlines the process of this research. The chapter discusses the research aims and questions and takes an in-depth look at the chosen research design. The researcher then describes the research setting, participants and the pilot study that was conducted. The chapter further outlines the procedures taken during data collection and the methods used to analyse data. The credibility and quality of the research was then investigated, scrutinised and described in detail.

CHAPTER 5

RESULTS

Overview

This chapter will outline the various themes that have emerged from the analysis of the data gathered. The results have been divided into either systemic or interpersonal categories with themes located within these two main categories. The chapter includes critical incidents to illustrate emerging themes. The chapter further includes a section on what participants envision for the future of the hospital and what interventions the participants believe is needed to improve interprofessional conduct and communication at the hospital.

The results in this chapter are divided into 4 sections:

Section A – Goffman's Front and Backstage

Section B – Systemic Results

Section C – Interpersonal Results

Section D – 'The way forward', participant's reflections on the future of the hospital

SECTION A

Goffman's Front and Backstage

Communication in the hospital did not appear to have a clear front or backstage in terms of Goffman's categories. Interactions that initially appeared to be front stage in nature were observed changing into a backstage area, these changes would occur quickly and without warning, an example of this is seen in the critical incident below. In the hospital the role of audience and actor is often interchangeable due to the small number of hospital staff and depending on hospital staff involved in the interactions. In this environment, role identification of the actor and the audience is determined by the importance or power of the health care worker, their status and place within the hospital hierarchy. For example a hospital manager in a morning meeting may give information, negotiates, and settles conflicts and find solutions to problems. Here the manager's seniority, status and power when giving information makes him the actor while the doctors and nurses in the meetings play the role of the audience.

Yet in the same meeting, the roles may be reversed when a doctor or nurse presents a patient case to management. Power struggles in an environment are not new in health care and can occur between two professional groups who are trying to achieve a mutual goal or when expanding professional boundaries (Gilbert, 1998). In this research role reversals between the audience and the actors did depict power and mirrored the hierarchical structure of the hospital. Boundaries appeared blurred due to unclear actor and audience roles as well as undefined working environment spaces. Medical

geography has examined some of these issues related to the influence of space in health care (Jones & Moon, 1993), the health care workers in this study appear to not only have undefined working space but also undefined social space which can be seen in the critical incident below. The critical incident below describes how in a typical morning meeting the front and back boundaries can become blurred and undefined.

Critical incident: This incident was observed by the researcher at one of the multidisciplinary morning meetings.

Staff arrived for the meeting and group according to profession, status, age, race, friendships and nationality. Before the meeting started staff talk about their weekends, joke and sing. The atmosphere is very relaxed and welcoming.

One of the doctors comments that it is time to start the meeting and all health care workers take their seats and stop their conversations, the meeting is opened with a prayer. The atmosphere changes and becomes formal and serious. Health care workers discuss a challenging case and a senior doctor queries their methods. Another doctor backs up their methods and the senior doctor then agrees with their decision. Health care workers discuss a patient who needs to be transferred but that they have been unable in getting another hospital to accept the transfer. There appears to be a lot of frustration when the health care workers talk about transferring patients or communication with outside hospitals.

The tension is then broken by one of the doctors who makes a joke. The group laughs and some informal conversations start about who is the best and who is the most attractive. The meeting then continues but it is less formal with nurses and doctors leaving to answer phone calls and playing on their phones. The room is hot and the health care workers ask for the air con to be switched on. One of the junior doctors stands on the conference table with no shoes and switches on the air conditioning. Some of the nurses and doctors laugh while the senior management appear irritated.

The above example illustrates how boundaries appeared blurred due to unclear actor and audience roles as well as undefined working environment spaces. While there were

blurred boundaries between front and backstage, examples of interactions and communication with interprofessionals were observed taking place in both the front and backstage. Observed examples that were noted by the researcher included social conversations in front of patients and other health care professionals and a lack of formal language and structure in interprofessional meetings. One reason for the hospital not having defined space may be due to its lack of private spaces. Lewin and Reeves' (2011) study noted a similar lack of private space where health professionals could avoid interruptions and speak freely and interact socially.

Planned front stage, an interaction that occurs in a public space and that is often routine in nature, was observed during ward rounds where professionals followed structured activities which were often routine in nature (Murphy, 2009). Interprofessional interactions during ward rounds were observed between doctors and nurses where hierarchical status was demonstrated. Doctors appeared to hold the position of power in these interactions with nurses only adding to the conversation by requesting clarity on an instruction given. All observed activity in this planned front stage interaction took place around a task orientated goal. Yet the doctors and nurses appeared to work parallel to each other rather than together.

Unplanned front stage interactions which are interactions that are still visible to the general public but are not planned or structured, were most commonly seen in the corridors between wards. Here communication was brief and still maintained its formal

element. However it was observed that these interactions started as unplanned front stage and usually turned into unplanned backstage with professionals discussing personal issues or joking. The change between the two stages was relatively quick. This was seen with doctors and allied staff, allied staff and nurses, nurses and support staff.

There is limited research into ‘corridor conversations’, even though they occur daily within hospitals and clinics and are an important part of interprofessional communication. Corridors are seen as a compromised area to communicate as conversations can be overheard, there is no documentation and it is viewed at an inappropriate space to deal with medical conflicts or issues (Long, Iedema & Lee, 2007). A qualitative study looking at factors that create a successful HIV/AIDS clinic found that small talk conversations that occurred in the corridors were beneficial as they helped rapport building between professionals and patients due to the neutral space in which the conversation was held (Watermeyer, 2012).

Planned backstage was observed during parts of the hospital’s multidisciplinary meetings, as seen in the previous critical incident where health care workers prior to the meeting use the space to discuss their weekends or joke. These meetings occurred in a private space away from the general public and in a closed room. As with Lewin and Reeves’ (2011) study, observations found that individuals would come and go as needed during planned back stage activities. In general attendance was poor and communication was often interrupted by an individual arriving late or the absence of an

individual who was needed to make a decision. This negatively affected the flow of efficient and effective communication in this setting. While the planned nature of this interaction prompted formal communication, professionals were more likely to share personal information such as stories related to their personal lives which aided in building relationships. Another area that is associated with the planned backstage space is the theatre, the critical incident shows how backstage relationships vary and how important this back stage is for developing relationships.

Critical incident: This incident was observed by the researcher in the operating theatre.

Prior to the surgery the doctors and nurse are sitting in the tearoom. The atmosphere is jovial and all the doctors and nurses have put money on the table to buy chicken for lunch. Two of the doctors are talking about the previous patient they operated on, “I’m worried about that lady. It’s a quick fix solution, if she gets worse she might need a real doctor to see at it.” The other doctor laughs at the other doctors for not considering himself a real doctor and tells him not to worry.

The patient is wheeled in and the doctors and nurses take their place and start their set routines. Swabs are counted and doctors check all of the equipment. Before the doctors begin a nurse asks that they recheck the drip. During the operation the doctors chat amongst themselves and give each other affirmations, ‘yes that looks good.”

The doctors and nurses joke. One nurse comments that she is tired and the doctor replies, “Is it because you are old or because I wore you out?” There are lots of sexual references and flirting.

Doctors help nurses with cleaning up after the procedure. A nurse jokes with a doctor when he asks her to finish making notes, “Ah, I am your assistant but that is your job.”

The theatre was a unique environment as professional hierarchies appeared less apparent and professionals chatted informally during surgery, sharing jokes and flirting (Tanner & Timmons, 2000) and clear examples of this can be seen in the critical

incident above. One doctor commented, "*I think communication can be quite odd in the hospital. I have seen some odd bits of dialogue. There seems to be an awful lot of flirting, sometimes in the theatre setting for example."* The operating theatre is one area in the hospital that did not appear to be interchangeable in terms of front and backstage. This may be due to the patient being sedated and not aware of health care workers conversations, secondly health care workers have time for informal communication and use this time to build relationships while working (Gardezi, 2009).

The most interesting area of communication found by the researcher was the unplanned backstage as it seemed to represent an area where professionals could communicate freely. Communication in the unplanned backstage was seen to be informal, relaxed and unstructured. Communication was opportunistic, with the nurses' station playing a large role as found in the Lewin and Reeves' (2011) study. The nurses' station was observed as an area where numerous professionals gathered (see photographs 5, 6 and 7). Nurses and doctors used the area to write notes and informally discuss patients. Other professionals like allied staff and support staff came into contact with this area on a regular basis either using the space to make notes or asking the nurses about a particular patient. This backstage space appeared fragile however as it was situated in the middle of an open plan ward and could be disrupted at any time by a patient, family member or other staff member.

Photograph 5: Doctor using the nurses' station



Photograph 6: Backstage interactions at the nurses' station



Photograph 7: Backstage interactions with allied staff at the nurses' station

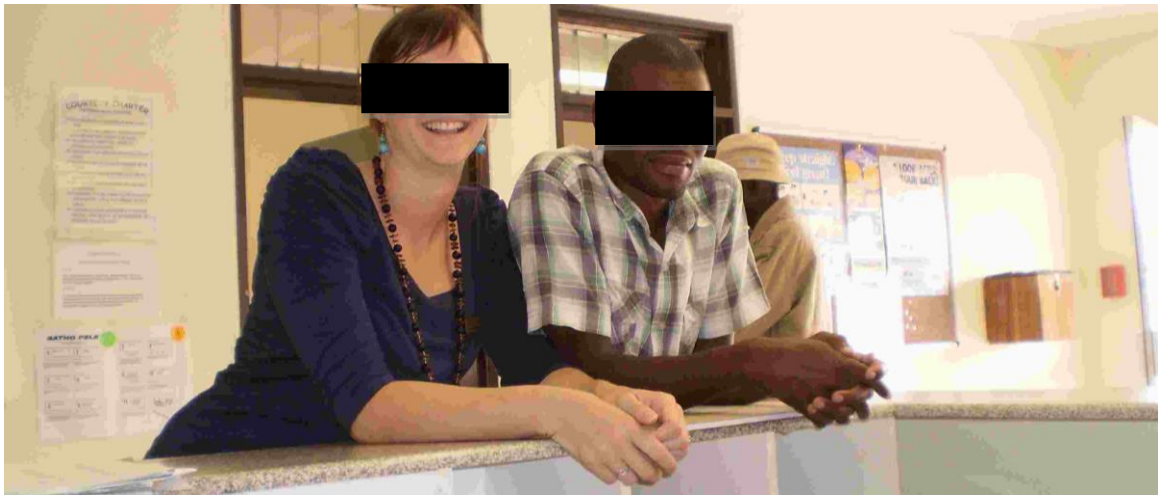


Table 5: Profile of participants according to setting, appearance and interactions

	• **Social Setting**	• **Appearance**	**Manner of interaction**
Support Staff	• Workshop • Entire hospital	• Overalls or uniform • Tools	Little interaction with other staff.
Administrative Staff	• Offices in the admin building • Filing room	• Smart-casual clothing • Files & forms	Interactions were usually initiated by a different profession.
Nurses	• Theatre • Wards • Casualty • OPD	• White uniforms • Badges • Files • Medicine	Huge variation in interactions.
Allied Staff	• Wards • Department • OPD	• Matching t-shirts • Lab coats	Interactions were less formal with medical staff.
Doctors	• Theatre • Wards • Casualty • OPD	• Smart clothes • Scrubs • stethoscope	Interactions revolved around instructions or requests with some social conversations
Management	• Office in admin block • Meetings	• Suit • Smart • Cell phone	Discussions used formal language and were brief and to the point.

Backstage communication that occurred here was important as it supported communication interactions that occurred in the front stage. The space also served as an area where staff could provide support, talk about challenging patients or experiences and develop interprofessional relationships (Wittenberg-Lyles, et al., 2009).

The above Table 5 shows a breakdown of participants setting, appearance and interactions. Props and settings were examined but seemed to have no impact on health care workers communication. This may be due to the lack of space within the hospital and familiarity between staff.

While Goffman's framework with Lewin and Reeves' (2011) adaptations provided some understanding of interprofessional communication it does not appear to sufficiently address all factors that influence communication in the rural setting and did not provide a complete picture of the macro influences in the research context. Therefore additional data and themes were categorised according to systemic and interpersonal themes like those seen in eco-social theory. By identifying themes and categorising them into these two categories is provides a more holistic view of not only the interactions between interprofessionals but also of the influence of the environment on these individuals. The below Table 6 shows how the results will be presented, as well as which category the results fall under.

Table 6: Systemic and interpersonal themes

Systemic Results	Interpersonal Results
1. Rural Influences	1. Communication
2. Rural Hospital vs. City Hospital	2. Management
3. Surrounding Community	3. Referral & Handover
4. National Health Insurance	4. Role & Identity
5. Support Systems	5. Power & Status
	6. Blame, Conflict & Responsibility
	7. Language

SECTION B

SYSTEMIC RESULTS

Systemic results refer to themes which influence and affect the hospital staff communication from external sources that are outside the hospital's control. Systemic themes in this category include rural influences and challenges, the perceived differences between a rural and city hospital, the community's perception of the hospital, services and support from head office and new health policies like the National Health Insurance scheme. Systemic results are numbers according to order and each result will be discussed individually with supporting data.

1. Rural influences and challenges

All the participants in this research reported on numerous rural challenges that they feel affect their daily life and the ability to perform their job. Challenges that participants reported facing within their environment included poor socio-economic conditions, high burden of disease, working with a largely uneducated population, staff shortages, limited resources and the use of traditional treatments over biomedical ones. These were similar to the rural challenges identified in the literature in chapter 2.

The most common challenge that participants mentioned was education, in particular working with a population with lower education levels. Health care participants felt that patient's education was often crucial to their successful treatment. Educated patients are more likely to seek health services on time and adhere to medication guidelines (Ensor & Cooper, 2004).

Table 7 contains an illustrative quote that expresses frustration over patients using traditional medicine and seeking intervention from the hospital after exhausting all other possible means. Participants in this study reported that patients from the local community often sought services late as they chose to first use traditional methods to address health concerns.

Table 7: Illustrative quotes on rural challenges from interviews and focus groups

Interviews	Focus Groups
Support staff: They believe in traditional healing medicine, they exhaust most of their time there and when they come here it's late. I think rural area it it's very rural because people here they are not educated firstly so it's very difficult to change the mindset of a person who didn't go to school. And they you know are not willing to learn.	*Allied staff: (A) rural area is not an attraction to professional. I mean, they come and go, people come for different reasons. They get, they advertise for job, they get senior post, just come here to get a senior post.*
Management: We are in a rural area, there are no doctors. It is difficult to attract those skills which are very important in the hospital because of the schooling around here. There are no private schools; there are no towns, no accommodation so those things are causing a lot of problems and challenges.	*Support staff: Most of the health facility at rural you see they have a similar problems because at clinics they will send you to the hospital of which by then you are very sick when you arrive here you won't get that help or an assistant immediately because you find people. There you will queue.*
Allied staff: There's no access to internet, we don't even have a computer.	*Allied staff: There's not a lot of incentive for actually staying here*

Participants felt that many of the community members who visit the hospital do not listen to advice, education or recommendations given by staff and thus felt helpless in changing some individuals' perceptions. This was particularly frustrating for the doctors who reported that they were unable to medically intervene and provide help at such a late stage. Seeking late treatment at the hospital may be a symptom of the community's lack of trust in the hospital, leading members of the community to attend the hospital only as a final option.

A theme and a challenge often discussed in individual interviews and focus groups were issues relating to access to the hospital and the health care system in general such as physical distance between the hospital and a city and access to tertiary health

care institutions. Being rural, patients often have to travel far distances to receive treatment and transport to and from the hospital is costly. Patients who rely on a wheelchair for mobility often will have to pay an additional charge for the transport of their wheelchair and typically have a person who accompanies them (Bateman, 2012). Isolation was not only present for the patients but also for the staff due to distances from referral hospitals, city life and lack of resources. These findings were similar to those identified in the current literature (Brems, et al., 2006; Hart, Larson & Lishner, 2005). To reduce the high burden on the hospital, patients must have a referral letter from their local clinic. However these clinics are often under-resourced with only two of the fourteen clinics being visited once a week by a doctor from the hospital.

Staff shortages are common within rural hospitals. This typically results in long waiting lists and queues for patients and overburdening of staff. A possible cause for staff shortages may be related to the majority of the educated population in the area surrounding the hospital migrating to more urban areas for employment. Similarly there are a lack of professionals who wish to work at the hospital for various reasons. Staff retention in rural hospitals is low (Chipp, et al., 2011). The hospital staff has limited access to support structures such as forums where profession-specific groups meet to discuss provincial issues and supervision, and rely mainly on landline telephone to communicate with health care workers in other areas. There are limited training opportunities in the area and participants noted feeling disconnected from the outside world.

2. Rural hospitals versus city hospitals

The participants' views about differences between urban and rural hospitals differed, but these differences were not profession-specific. Some participants felt that there were advantages to working in a rural setting as opposed to a city hospital, such as a sense of familiarity and a close team. This, however, was not a common view and was mainly held by doctors who work in small teams. The doctors described their peers and the setting as familiar whereas they felt an urban setting would be more rigid. The doctors appeared to have built close relationships which allowed them greater leniency which they reported they had not experienced in an urban setting.

Roughly half the participants commented on similarities between rural and urban hospitals but stated different similarities. Some of the participants commented that all hospitals would be the same if they were run by government and that these government hospitals would have negative connotations. Participants commented on rural and urban hospitals being similar with regards to poor staff attitudes and a lack of empathy shown by the staff.

The remaining participants felt that working in a rural hospital was different to working in an urban setting, specifically with regards to communication between professionals. Participants reported that they felt communication within a rural hospital to be more

familiar and a difference in channels used to communicate for example using the telephone versus internet was raised. A recurrent theme around a lack of resources at rural hospitals arose during interviews and focus groups. Participants felt that a lack of resources available within rural areas was a contributing factor to poor communication. Urban hospitals were noted to be different because they are better staffed and have specialists and health professionals with greater experience. One participant felt strongly that some staff in rural hospitals work only for the money and are not passionate or interested in their patient's outcomes, which the participant felt was in contrast to urban hospitals who do not receive additional rural allowance.

3. The surrounding community

One unique aspect of this research is the role of the community and interactions between the community and the hospital. As previously noted in chapter 1, the surrounding area is known for its high levels of unemployment, HIV/Aids, poverty and poor education (CRDP, 2012; Newcastle, 2012; Medicalchronicle, 2011). However, the hospital is often not the primary treatment option.

The majority of the community still uses traditional medicine as a primary treatment option before travelling to the hospital for what is viewed as "western" or biomedical treatment. Religion also plays a role in treatment decisions as many churches in the area offer faith healing. The above Table 8 contains references to the hospital's nickname as well as health care workers views. The support staff interview quote

described how the nickname was derived. Participants in this study reported that the community have named the hospital "*Emvakwakho*"- 'the place of no return' or 'just after you left'. The name is believed to have come from a belief within the community that if an individual is brought to the hospital, as soon as the family leaves the patient at the hospital, they will receive a phone call that the individual has passed away.

Table 8: Illustrative quotes on community views from interviews and focus groups

Interviews	Focus Groups
Support staff: They not happy at all because they called it Emvakwakho something like that I don't know how to translate that but it's like if you just leave here and are five minutes away we call you back, something wrong happened. So it's like when they left their relatives here maybe within an hour they get home, they get a call that somebody… that person passed away because of the poor service.	*Support staff: You will see careless, it's a pity I will tell a story: as a cleaner when I do my rounds, sometimes you will find that sometimes the patient will be dead discovered by me. [Cleaner is the first to find that a patient has passed away]*
Support staff: I cannot say it is good because people are complaining outside. They come here and they stand in a queue for a long time.	*Administrative staff: They call it a slaughter place.*
Nurse: The community is crying and they cry I don't blame them, because if you are an outpatient they are here every day, on that we have set times and they go home without being seen and they are from poor communities. They are not working; they are living on a grant that is only a little bit of money. So the community if not satisfied generally speaking and even if I was a member of the community I don't think I was going to be satisfied the way we give the service.	

The community's trust in the hospital was mentioned throughout all health care workers interviews and focus groups. Trust is important in the health care setting as if patients do not trust the service they will receive they may not attend follow up appointments due to a lack of confidence in the health care workers ability. In Watermeyer's (2012) study staff acknowledged the importance of building a relationship with patients however this was not acknowledged with the staff in this study. By not building relationships with the local community it appears as if the health care workers have further isolated themselves.

Community perspective

Participants such as the hospital administrative and support staff seemed to strongly represent the community and reported on the community views as the participants often grew up in the area and are still staying within the community. These participants were frustrated with the type of services that the community received and noted the long queues and waiting lists. The researcher observed that on Out-Patient Days at the hospital, patients would arrive from 6am in the morning and the queues could last into the afternoon. The doctors would close the consultation rooms at 4pm and patients who were still waiting would be asked by the nursing staff to return on another day.

Support staff participants' main concern about the hospital included the prevalence of a negative attitude shown by staff, particularly nurses. They felt that nurses used their status and authority over patients and had negative attitudes towards the patients they treated. This was surprising as the majority of the nurses at the hospital are from the local area. This issue may be related to the nurses' issues surrounding identity which will be explored in chapter 6.

Participants who come from the community further acknowledged cultural aspects related to health care. The first aspect was the use of traditional medicine over biomedical medicine. Participants noted that the community has been using traditional methods all of their lives and have a mistrust in western treatments. There appears to be a parallel existence of the two methods with the local population often using both approaches simultaneously. The second aspect was the importance of religion, usually Christian, within the community. Numerous churches exist in the surrounding Nkomazi area, and many practice faith healing. The majority of staff and patients within the hospital are Christians. Faith healers and preachers were observed in the hospital wards praying over patients or casting out 'spirits'. It appears that individuals from the area use both religion and traditional practice together. For example it was not uncommon in the hospital to observe patients who would have a preacher visit and would use a traditional treatment simultaneously. In these instances patients were not only seeking dual consultation but triple consultation. The ramifications of which may lead to poor adherence to medications, medical intoxication and poor health seeking behaviours.

The final aspect the community participants mentioned was a cultural view of respect. In the Nkomazi community there is a large and repeated emphasis on respect and learning from the elderly according to the support staff participants. Communication with elders is more formal, direct and courteous than normal day-to-day interactions. Depending on the culture, there are special actions that a speaker must use when talking to the elderly such as bowing of the head, not making eye contact or kneeling at the elder person's feet. Status and education is also respected and thus it was reported that locals from the community immediately respected doctors even if they may be young and have not traditionally 'earned' their respect. One participant spoke about how elders fear the hospital as it is an unfamiliar place where one goes to die, '*a doctor is someone we are usually scared of in the communities, us as black elderly people when you are thinking of taking him/her to the hospital, some still believe that at hospitals is where they are killed.'*

All of the participants interviewed were aware of the community's negative perceptions of the hospital. While many of the participants acknowledged patient difficulties, many felt that the hospital's nickname was unfounded. It was interesting to note then that not one of the participants said that they would seek services from the hospital, unless they had no choice. This is not unusual in the South African context were the majority of the population would seek private health care services over public health care if they can afford the cost.

Patients have to wait in long queues in the out-patients clinic to see a doctor and it is not uncommon within this hospital to wait for a consultation only to be asked to return the following day. Hospital staff were aware of these issues but felt helpless to address this area of concern without more staff and a better referral system from surrounding health care facilities.

Hospital staff in turn reported feeing disconnected with the community. As the above quotes in Table 8 illustrates, staff feel many of the claims are unjustified and relate more to the area's socio-economic conditions in the area. Staff from the community often seemed to identify first with their profession and then with their community. The only group who first identified with their community were the groundsmen and cleaners. These participants spoke from the perspective of having to use the hospital as they had no other option.

Management's perspective on the community

Management appeared to have a similar view about the community as that of the health staff participants. Participants in managerial positions appeared to have noted the disconnection between the community and the hospital. However no one seems to have addressed this issue and this was not directly discussed. One participant in management said, "*We don't have structures in place to link us properly with our communities. At times the community is fighting us because they don't have information*

and we don't know how to communicate the information we have so when they come to the hospital they don't get the service they expect so they know the reason." These results demonstrate the importance and the power of communication and that communication needs to be extended beyond the hospital.

4. National Health Insurance

The data in this study were collected in May 2012, the same year that the South African Department of Health began implementing the National Health Insurance (NHI) pilot programmes. This topic was not initially considered as part of the research question. However during the focus groups and interviews it became apparent that health care workers were concerned about the new system and this topic formed a significant part of their responses.

This section is the only one where exact percentages were used to further illustrate results, this has been done to emphasis the understanding that participants have of the NHI scheme. It was surprising that not all of participants interviewed had heard about the NHI as there had been a large amount of media coverage surrounding the launch of the pilot projects. Moreover, only several of the participants interviewed had received information about NHI from the hospital where they are employed. The majority of participants had only gained information about NHI from external media sources. Interestingly, the participants who reported they had received information and training about NHI from the hospital were all in managerial positions such as heads of

departments. Only a handful of participants interviewed felt that they understood NHI and how it would be implemented. There appeared to be a large amount of anxiety amongst participants due to the uncertainty and lack of knowledge about the NHI that is expected to directly impact upon them (see Table 9). Participants were frustrated that they were not informed of health changes, especially those that impact on their own profession's service delivery and core compliance standards. Many participants commented that they would like to be informed, and involved in decision-making and implementation of NHI and make suggestions based on their personal experiences.

Table 9: Illustrative quotes on National Health Insurance from interviews and focus groups

Interviews	Focus Groups
Management: We heard it from almost everywhere but the most it is from the provincial office because normally in the position that I am in I am interacting a lot with the HOD and the MEC so in those meetings that we have we usually discuss about it.	*Allied staff: What does this thing mean to me as a worker? I am working mina (me), so what does it mean for the person working outside? You see so there's a lot a lot of speculation around this thing we don't know anything about it.*
Doctor: I would say the communication's very poor from Motswaledi to MEC to Dr (x) to us. There has been no information session to say uh 'close your eyes, imagine 5 years time, this is what it's going to look like'. So we are guessing still. None of us as doctors talk about it so it's so far away that it's not relevant at all right now.	*Allied staff: the pension money that's the area of concern if they are going to take my pension money what if I want to retire the next day so if they want to utilize that money but people should have come out and tell us clear that this is how it's supposed to be done*
Allied staff: I wish I had more information especially on the ground level, maybe some senior person coming to talk to us…what is it exactly, having unpacking it. As for the details, I don't have a clue.	

During the focus groups and interviews three myths surrounding the implementation of the NHI scheme emerged.

1. NHI would replace medical aid and private hospitals would now be paid for by government.
2. NHI was started by the unions and therefore must be supported.
3. NHI will badly affect health care workers as it takes away their entire government pension to fund the running of the new system.

These three myths seem to show misunderstanding and confusion in the communication of information in the hospital system. These three myths show how communication has not only negatively impacted on health care staff but has created confusion, misinformation and anxiety. NHI appears to be a microcosm of the state of communication within the hospital. Information was received by management. However it seems that the information has not been successfully distributed down the appropriate channels. This led to a rise in misinformation due to information coming from a variety of other sources. Further this may be seen as an example of information power and gatekeeping, which happens when information is withheld by an individual or specific group as power is related to the information they possess (Roodt, 2009). This calls in to question who in the hospital has claim to knowledge and how this may be related to their status.

While NHI has been spoken about in the media there seems to be very little understanding about its implications and effects. No current research looks at rural health care workers' perceptions of NHI and their level of understanding. McIntyre (2010) warned that in the implementation of the NHI, it is important to have the frontline workers on board. Past experience has shown that introducing new policies without effective training or poor consultation with workers can impact on staff morale (McIntyre & Klugman, 2003).

5. Support Systems

Although this was not a focus of the study, it is important to note the influence of external support systems on hospital communication. In general participants felt unsupported by their provincial office and had little communication and interaction with other government offices such as the South African Social Services Association (SASSA). An allied participant noted she was unable to contact the provincial coordinator as she was new to the post and did not yet have an office phone. If the coordinator needed to be contacted urgently she had to be phoned on her personal cellphone. This made contacting her for support difficult and infrequent.

Provincial support systems appeared to support only managerial staff or heads of departments, perhaps with the goal or intention of the support and communication of information then being passed down by these individuals to those whom they manage. However this system did not appear beneficial to participants.

SECTION C

INTERPERSONAL RESULTS

Interpersonal results refer to themes which influence and affect the hospital staff communication from internal sources. Interpersonal themes in this category include general communication in the hospital, management issues, referral and handover, roles, identity, power and status of health care workers, blame and conflict in the hospital, responsibility and language issues.

1. Communication

The researcher observed communication processes around the hospital. The majority of communication in the hospital was done face-to-face or telephonically. The most common spoken language during these interactions was siSwati followed by English. Communication between professionals was usually task-orientated, brief and formal in nature. The most common form of communication seen at the hospital was generic greetings in siSwati. This greeting further served as a form of cultural respect and acknowledgement. Greeting was seen to be an important social aspect in the hospital. Hospital staff greet continuously throughout the day and all staff regardless of first language or background are encouraged and expected to respond with basic greetings in siSwati. Not all staff in the hospital were greeted and this was seen as insulting and related to low status.

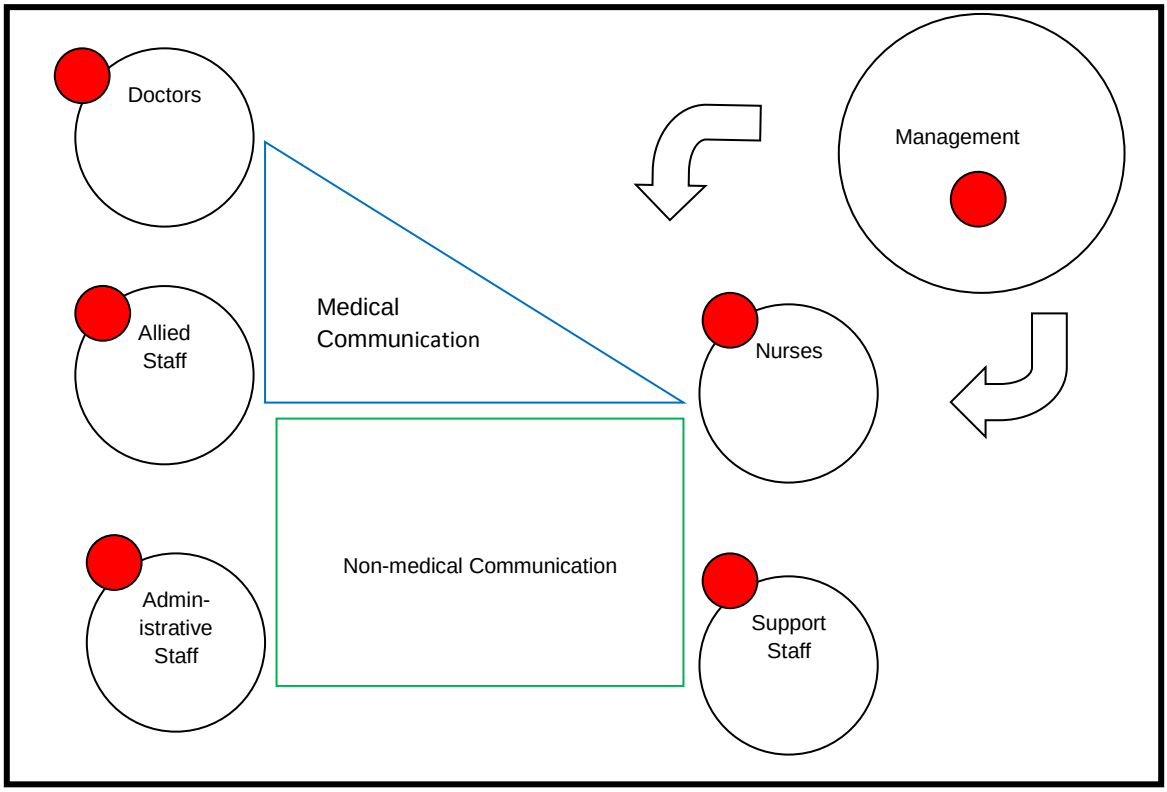
Table 10: Illustrative quotes on communication from interviews and focus groups

Interviews	Focus Groups
Doctor: I think communication is very variable. I personally think communication is quite bad when I am there as I have to rely on a translator. I'll ask a question and often there will be a long dialogue between the nurse and the patient. It may be a simple question like when did something start, they will talk for ages and then I get an answer that has no bearing on what the question was at all. I miss out on a huge amount of the communication that people are actually having and I must try piece things together.	*Allied staff:* [Referring to a doctor in the hospital] *No communication, doesn't answer his phone. He has several phones and you'll finally you'll get the number to his new phone and you dial that and it works for a little bit and then he'll swap the sim-card again because too many people know and so things can't get signed, things are not managed.* *So no I don't think the communication is always that good. And you can see it even with referrals from doctors to us; it's often expected of you to know what to do without someone actually saying it to you.*
Support staff: They (hospital staff) do communicate well sometimes, it depends on circumstances. Sometimes poor sometimes good, it depends, it goes up and down.	*Doctor: I think last year when we had a lot of doctors or even now, because you're a small group, a lot of people are also friends so it makes it easier to communicate. But on the other hand last year we were twenty doctors and there were different groups of friends and you see those groups were actually sometimes fighting stuff out at work.*

Participants reported that communication in the hospital was inconsistent especially when working in an interprofessional team. Quotes about inconsistent communication can be seen in Table 10. Staff who were not fluent in siSwati relied on ad hoc interpreters. This will be described further in the next theme (language issues). Other issues raised by participants surrounding communication included poor communication channels and familiarity with staff. In Table 10 an allied staff participant describes how it is hard to contact some individuals: in this example the rehabilitation department was unable to contact the rehabilitation coordinator as she did not have a phone.

Communication in the wards, Out-patient department and casualty were usually brief, formal and the topic was task related. This was a stark contrast to communication observed in the theatre. Participants' communication in the theatre environment appeared more relaxed than in any other hospital environment. Doctors and nurses were observed socialising and discussing aspects of their personal life. This was not seen between doctors and nurses working in the wards. All participants in the study felt that communication in the hospital could be improved. Further, the tone and style of communication appeared to be linked to hierarchy and the health professionals' status. This study confirms that multiple factors affect communication (Iedema, 2007; Penn, Watermeyer & Evans, 2011).

Figure 6: Communication between health care workers



The above Figure 6 represents communication patterns observed within the hospital. The red circles represent managers or head of departments (HOD) within the profession. Management communications with all of the staff in the hospital, however they appear to only communicate with the manager or HOD. The blue triangle represents the triad of medical communication that occurs between doctors, nurses and allied staff. The majority of communication observed between these health care workers was task related. The green rectangle represents non-medical conversations that were observed between nurses, allied staff, administrative staff and support staff, these conversations were centred around administrative or maintenance tasks. Figure 6 provides an understanding of communication channels within this study and does give insight as to how hierarchical levels are structured, with administrative staff and support staff having little or no contact with doctors and managers.

2. Language

Language issues were only mentioned by a small percentage of the participants. These participants were either white urban South Africans or foreigners. The majority of the participants were fluent siSwati speakers who had conversational English skills, yet for those who did not speak the local language they had to rely on colleagues, ad hoc interpreters or make do using gesture or basic phrases.

The use of impromptu or ad hoc interpreters gave rise to a number of issues (Penn, 2007). Firstly these interpreters were usually nurses who are untrained interpreters and have other responsibilities to complete. As seen in Table 11 one doctor notes the difficulty of obtaining information through this 'broken telephone' method. Secondly using a nurse as an interpreter can lead to the nurse feeling used and underappreciated. An ad hoc interpreter such as family members or friends of the patient can also jeopardise the confidentiality of the patient as well as the flow of communication as the patient now has to disclose their personal information to two individuals instead of one (Penn & Watermeyer, 2012). Other aspects that were reported included speaking down to patients due to poor language skills, which one participant described as 'baby speak'.

Participants also felt frustrated as limited communication affected some of the health professionals' ability to perform their job and they felt *'lost in translation'*, as seen in Table 11. An allied participant expressed his frustration at trying to complete an assessment without an interpreter. This participant reported that without some crucial information he could only treat what he saw. These findings confirm the need for training cultural brokers in the South African health care setting (Penn & Watermeyer, 2012). Yet the need for interpreters for communicating with patients is different to needing an interpreter to communicate with colleagues. Language barriers between

colleagues may lead to health care workers avoiding communication and not communicating as a team.

Table 11: Illustrative quotes on language issues from interviews and focus groups

Interviews	Focus Groups
Doctor: Ja sometimes you do because sometimes the translators they uh they don't speak English very well. Most of them they do but they actually not trained translators they actually nurses who have to interpret what the doctor wants and have to interpret what the patient says. It's simplified as well and if you want to do an in-depth history of a patient, you'll never get there because sometimes the nurses don't understand the questions and then they just ask the patients where they have pains.	*Doctor: I think there's also some issue with the communication with the patients. It's almost easier than where we previously worked because I find in casualty the staff is very willing to help you translate and they're always there. Whereas other situations often you're just left on your own and there's no body in the middle of the night and you can't talk to your patient. So that I found here it's quite good balance because you always have somebody willing to translate and with regards to before we came to work here communication that was given across to us from the Hospital was good*
Allied: I think the big thing is the language barrier and also disrespect for different cultures. I often feel that is expected of me as an Afrikaans white person to speak SiSwati, where the people will not great you in English, they will demand that you speak SiSwati.	

3. Management

Critical incident: This incident was observed by the researcher at the peri-mortality meeting.

The meeting is attended by management including the new CEO, doctors and nurses. The meeting starts with a brief introduction by the medical manager and a group of nurses stand up to begin their presentation. After the nurses have presented their case the CEO asks why they did not provide more details and why they have not mentioned the names of the nurses and doctors involved.

The senior matron becomes defensive and says to the CEO, “this is how we usually do it, I think this is your first meeting.”

The medical manager then replies, “The reason we don’t bring the files is because we don’t want this session to turn into a witch hunt for the clinicians involved.

Staffing shortages though recognized as a common rural challenge were identified by participants as a barrier to communication (Bateman, 2012). Shortages affected communication due to staff feeling over-worked and having less time to communicate with other health care workers as well as not being able to communicate with relevant personnel, as posts were vacant (see Table 12). For example the support and administrative staff repeatedly referred to a time period in 2011 where there was no hospital CEO. The absence of a CEO resulted in staff being unable to order essential stock or hire new staff members, and a break-down in communication with the Mpumulanga Department of Health Head Office. This event appeared to have long-reaching consequences as many participants appear to be sceptical or distrustful of management, often citing this specific example. In the above critical incident, the nurses’ reply to the CEO appears attacking. In the incident the nurses feel threatened by the CEOs questions and instead of answering his question they comment on the fact

that he is new and does not appear to understand how things work in the hospital. A support staff participant noted, "*That is why he* [work peer] *was talking about the CEO, the CEO alone can't run a hospital. He needs people who are competent in the field, so now as I see it this hospital is lacking. We sometimes ran the hospital without a CEO, a month sometimes struggling to get small things but the hospital was still running."*

During the interviews and focus groups, it was the nurses and doctors that reported feeling the staff shortages the most. The allied staff quote in Table 11 also seems to give the impression that some of the hospital staff have a sense of helplessness. The hospital's organogram indicates that 36 doctors are needed, however at the time of this study, the hospital was running with only 11 doctors on staff. While the nursing staff were running at 90% capacity they still noted that staff shortages affected their performance. Staff shortages in turn affect the population that they service as less staff leads to longer waiting times and delayed treatment for patients.

The medical manager at the hospital seems to be required to take on dual responsibilities. Firstly he is a medical doctor who has his own ward rounds and secondly he is the manager of the medical staff. This is an example of crossing the professional-management divide which may be complex as the individual has to balance professional responsibilities and organizational responsibilities (Iedema, 2003). Decisional, informational and interpersonal aspects are the three main roles that managers need to embrace. A previous study (Odendaal & Roodt, 2009) examining

effective managers found that the difference between an average manager and an effective manager is the amount of time they spend communicating. Effective managers spend up to 44% of their time communicating with their employees.

Table 12: Illustrative quotes on management from interviews and focus groups

Interviews	Focus Groups
Support staff: If we got a good CEO this hospital would run very smoothly	*Allied staff: I think it comes a lot from top management. Definitely if management improves and certain structures are put in place like um like a more standardised way of how to refer and how to communicate, if it comes from the top it is important. Because I think often I find that here at the bottom we are trying to improve communication. But then especially with the older people or the ones that have worked here longer they will just think that you are a newbie or a new one at the hospital and you are now trying to change everything and they kind of laugh behind your backs because they just say 'eh it's not going to happen, you will see, nothing is going to change'.*
Admin: Its different, let me just put the scenario here at Tonga Hospital, we had a CEO last year um for 6 months she was not here. I admit there were problems. There were these acting CEOs they were just alternating, just one week or two and we could not get the information from them.	
Nurse: Here at the hospital, I can say its right, but there are some which say there's always a problem with communication especially when it comes to management. I just don't know if it's always there but there's that invisible tension that is there.	

For this dual professional role to work, the individual needs to develop a different occupational identity from their previous medical identity (Oliver & Keeping, 2010). This identity needs to be a dichotomy between clinical and managerial roles. This role also requires changes to their front stage appearance as the individual now represents both themselves as well as the hospital. This is a complex role within the hospital system and training should be given to the individual to aid this development.

Procedure such as ordering stock, was noted as a factor that may influence communication. Procedures not followed often led to conflict between professionals and were interpreted as disrespectful, participants felt their professional roles were being undermined. The topic of procedure was most commonly mentioned by administrative and support staff who most often used administrative/ ordering procedures. These participants reported that other staff were deliberately not following specific procedure. Medical, nursing and allied staff reported that procedures were often changed without informing them. Regardless of the breakdown, procedures appeared to be an area where miscommunication was common. Another potential reason for communication breakdown during set procedure may be the lack of organisational routine. Organisational routines encourage successful teamwork as they provide a sense of identity and roles and responsibilities within the task are defined (Watermeyer, 2012).

4. Referral & Handover

Interpersonal referrals, or rather the lack thereof, negatively affect communication between professionals (Greenwald, et al., 2006). Allied participants reported the most difficulty with receiving appropriate referrals from doctors and nurses. Two scenarios were discussed as frequent occurrences in the hospital. The first was health care workers not referring patients to the correct health care worker but other health care workers who are seeing the patient become upset when patients had not received

services (refer to allied staff quote in Table 13). The second was professionals referring to health care workers but making inappropriate referrals.

Handover was an important theme for medical staff (doctors & nurses). Poor communication in this instance not only affected the doctors' ability to perform their job but also affected the outcomes for the patient (McCann, McHardy & Child, 2007). One doctor participant expressed anxiety about walking into a ward every morning and not knowing the severity of the patient in the ward, and referred to this scenario as 'a lucky packet'.

Table 13: Illustrative quotes on referrals & handover from interviews and focus groups

Interviews	Focus Groups
Allied staff: So now, if the doctor or the other party or the other personnel don't actually call you to say there's someone in there I think you should see, chances are the person might just slip away without actually seeing a dietician. So, that communication still is not there because now sometimes you'll have to advocate.	*Doctor: I think nationally the communication the referral pattern is poor. I mean most provinces, Johannesburg is probably better but uh uh I think there's no set um cases where patients are accepted freely and in most of the provinces, North West and this one.*
Doctor: So every day it's a surprise what you'll find in the wards because you don't have a handover.	*Doctor: There is a major issue where there is no communication between the doctor leaving casualty and the doctor coming on. There's no handover and this is the first hospital that I've worked in where that doesn't happen. It's not uncommon to find very ill surgical patients needing a referral from part time workers and then there's just no hand-over, that's horrible.*

The below critical incident describes a typical handover scenario in the hospital. Although attempts by health care workers and management are evident in the below abstract, handover does not occur in the meeting as the health care workers who are required for handover are not present. The sessional doctors are not required to attend morning meetings however there are no other plans in place to ensure that information is correctly passed on. The second doctor is a member of staff and should have been at the morning meeting. The other health care workers do not appear to be concerned about the other doctor's absence and it appears that there are no ramifications for not attending mandatory meetings. The two doctors' comments at the end of the meeting show how other health care workers behaviours can impact on others.

Critical incident: This incident was observed by the researcher at one of the general morning meetings.

The morning meeting starts at 7:45am. By 7:45am only one doctor has arrived, and more staff arrive at 8:00am. Doctors and nursing sit at opposite sides of the boardroom table and grouping appears based on profession, age and status.

The meeting is running by the medical manager and the first topic is handover. The medical manager asks if there were any cases that need to be handed over from the night staff. There is a brief pause and another doctor comments that the doctors on call the previous night are not at the morning meeting as one of the doctors is a sessional and the other doctor has not arrived for the meeting. The meeting carries on without the mention of handover again. Two of the doctors start commenting about the doctor who did not arrive for the meeting, 'he never comes, why don't they do anything?'

5. Role & Identity

The theme of identity appeared to be unique amongst the nursing participants. These participants appeared to have dual and separate identities. All of the participant nurses in the sample were from the local area and still live in the community yet during the interviews and focus groups they did not identify with the community but rather chose to identify with their professional identity. Whereas the support staff appeared to identify first with the community before their profession. This theme will be explored further in chapter 6. Previous literature has noted that professional boundaries are often blurred in the rural health setting due to staff having to go beyond their professional responsibilities (Brems, et al., 2006). This blurring of roles was observed with participants in the study. As seen in the literature rural health care workers reported often working beyond their scope however within this hospital environment there further appeared to be a group who would not work out of their professional scope. This difference in opinion appeared to cause conflict between professionals.

This study confirmed the existence of blurred professional roles amongst the participants. Identity was linked with the theme of power which is explored in greater detail in the next section. While professional roles were blurred due to understaffing and high caseloads, participants reported many complications surrounding this issue (see examples of participants' quotes in Table 14). Blurred boundaries were often imposed on other professionals who felt that it devalued their profession and lead to conflict and

blame. Further it leads to professionals taking on the role of a 'generalist' (Nicols, et al., 2003; Wilson, et al., 2009).

Table 14: Illustrative quotes on roles & identity from interviews and focus groups

Interviews	Focus Groups
Support staff: No in [this] *Hospital there are supposed to be the higher people then the second one and the juniors. But like the juniors they act they act as if like they are you know superior*	*Administrative staff: They think we are not educated like they did. So they think that they know better than anyone. (nurses) Uh, I think it's, the problem we are having is we don't understand each other's job, what it, the processes and procedures.*
Doctor: For example one person was in theatre, I think they arrived late or they did something that displeased the person who was operating and she started answering back and saying oh well that's why I did it. He turned around to her and started saying 'who are you to have an opinion, you are just a nurse'. I couldn't believe that that sort of thing was being said.	*Allied staff: How is it ahhh… I can say that it depends who you are. We are not equal.*

6. Power & status

The below critical incident show how health care workers status and power may impact on how they interact and behave. The students, who are lower down in the hierarchy when compared to their teacher, appear to be anxious throughout the meeting. The doctor in this example uses his power by stopping the meeting, by enforcing an assignment and by disciplining the students.

Critical incident: This incident was observed by the researcher at one of the general morning meetings.

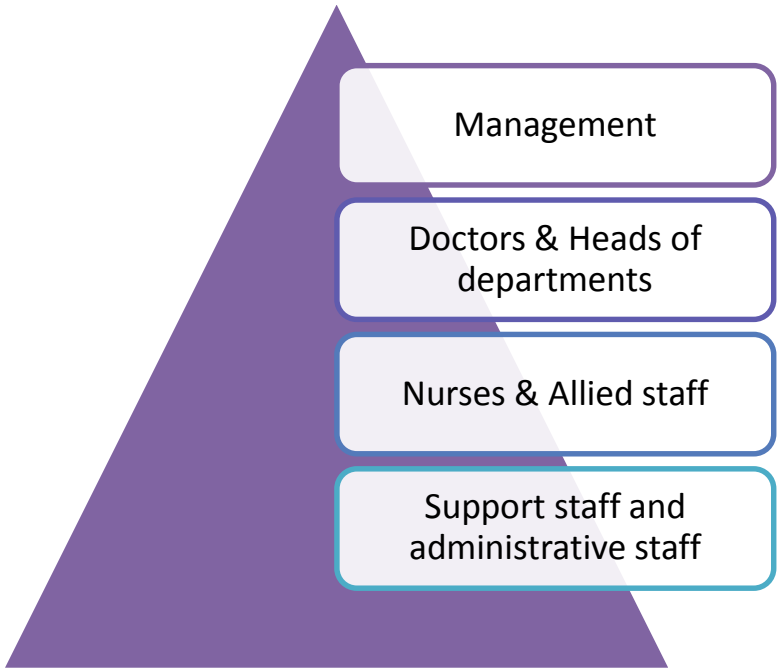
During the morning meetings, management and staff occasionally use the meeting as a teaching opportunity. One of the senior doctors who has managerial responsibilities stopped the meeting to ask the clinical associate students questions about a patient they were seeing. All 28 of the staff have stopped their discussion and are looking at the students. The students do not reply and stared at the floor. The doctor repeated the question and still the students do not answer.

The doctor becomes frustrated and replies, “I don’t know if you know anything! I have taught you this! Fine, then you will all have an assignment to do.”

At the end of the meeting the doctor asks the students to stay behind. The doctor says to the students, “Your quietness is annoying me, I don’t need to ask questions for you!” One of the students tries to respond but is cut off by the doctor. The doctor leaves and the students form a group and start talking about the meeting. Some of the students joke about the doctor; others appear upset by what was said.

Individuals in the hospital with the highest status seemed to hold the most power. Power is defined by a person’s authority to make and carryout decisions (Barrett & Keeping, 2005). At the top of a typical hospital hierarchy is management, followed by doctors, nursing and allied staff and then administrative and support staff, as seen in figure 7 below. In this hospital, the management structure that the researcher observed appeared to follow traditional hierarchal patterns with the CEO and medical manager found at the top of the hierarchy, similar to Figure 7. These individuals typically power features like confirming a decision, denying a request and having the final say in conflict resolution (Aas, 1997; Callaghan & Wistow, 2006). Yet due to their high level of power and status, big issues or difficulties in the hospital seemed more likely to be attributed to their failures or errors.

Figure 7: A basic hospital hierarchy



An example of this was seen in the critical incident under the management theme. Management do appear in this research to hold power due to their information that they hold, as seen in the NHI theme, as well as the ability to question the actions of the health care workers. While managerial staff seem to be the highest on the hierarchy due to issues of mistrust and lack of stability, health care workers do challenge their authority continually and power struggles between health care workers and management appeared common.

Internally within departments, there appeared to exist clear hierarchical structures. Power and status were linked as the higher an individual's status the more power they

hold within their job position (Ferrie, 2010). Similarly, this was seen with the administrative and support staff that were at the lower end of the hierarchical system. These participants noted that due to their low status within the hospital, they felt powerless. They reported feeling unable to give their opinion as it was not valued and they were the last to be informed about changes in the hospital. One participant spoke about how he does not fully understand their contracts as these have never been explained to he or it was explained in English which is not his first language.

Table 15: Illustrative quotes on power & status from interviews and focus groups

Interviews	Focus Groups
Allied staff: I don't think people communicate well here like I said. What I saw in most of rural hospitals, people they just do as they wish, they just anyone is just doing his own things. The information it's not it's not given in time for an example uh like doctors, they are the main people here in the hospital and that makes them to feel like other people they can't even tell them anything	*Administrative staff: What I can say is because people are not the same. We are coming from different families. Some of the colleagues they undermine others, let me take my friend here. Maybe she is a manager, so mina (I am) I am a junior staff. She don't respect me, she uses her powers as a manager. She don't care about me because I am not education, let me say I am a cleaner.*
Support staff: Usually the doctors don't talk to us, we sometimes see our self as if we are far behind because a doctor won't speak to me and then we have sisters, sisters in that way you will find that they are pressured and that that will be the time you will be able to talk to them but the working environment is not nice to us cleaners it is like we are living in another world	*Nurses: We do not have powers over the doctor, you call and they do not come, you do not have the powers of reporting that the lines of communication we do not have powers to report someone that you called and did not come. You will end up crying here and say that you called.*
	Support staff: So a person who is using his/her wages, me who is me as I am getting less I am nothing.

Participants further commented that staff higher up in the hierarchy do not communicate with then or even greet them, and participants believed this was due to their lower down

status in the hierarchy of the hospital and thus being viewed as uneducated. Other than education level, the salary that participants earned seemed linked to their status. Therefore a doctor's status is further elevated from a cleaner not only by skill or education level but also by the larger salary they earn. Support staff commented on how earning a minimum wage devalued their jobs and affected their self-worth, as seen in the support staff quote in Table 15.

Communication could be used to maintain control and power (Gardezi, et al., 2009). Other examples from the interviews and focus groups of power being withheld through the manipulation of communication included the following:

- Withholding of information between professional groups
- Partial information sharing that is deliberate
- Communication happening with a specific group only
- Communicating in a language which staff do not understand
- The use of silence by not replying to a request

7. Blame, conflict & responsibility

Critical incident: This incident was observed by the researcher at one of the doctors early morning theatre meetings.

As the meeting starts the doctors begin talking about the theatre schedule and any challenges that they may face in the day. One of the doctors asks for help as his wards are full to capacity and he has difficulty seeing all of his patients. No one volunteers to help. Another doctor then starts to complain that it is not fair when he is called to see patients at 4pm in the afternoon when work is finished. The other doctors stop their conversations. One of the foreign doctors then replies that he was phoned because he was on call yesterday afternoon. The remaining doctors agree by saying if he is on call then he must be phoned *"it's not a discussion, it's your job".* The doctors begin arguing as the doctor who complained about being called at 4pm argues that he should have at least an hour's break during the day and the other doctors should help him. The doctor who previously asked for help walks out of the meeting; he is upset. Another doctor then realises what has happened: "*let's discuss this logically, Dr x is stressed and no one is helping and then you blame!*" The senior doctor then tries to take control: *"when we speak, colleagues, let's speak like adults"*. The argument then returns to a previous problem "*its bollocks, it's not true; if you are on call it's YOUR job"*. During the argument the doctors raise their voices and hit the table. The senior doctor then tries to end the argument: *"we need to work as a team", "when we speak lets speak clearly and get our jobs done."*
After meeting all the doctors but the one who walked out and the one who complained about working at 4pm stay behind and discuss the doctor who complained and brand him as selfish and lazy.

This critical incident appears to represent a typical example of blame and conflict that occurs within the hospital. It demonstrates how blame can lead to conflict. Conflict appears to arise suddenly, resulting in a verbal outburst or hitting of the table and passed quickly. The most often mentioned cause of conflict across professionals was directed towards individuals or groups who did not take responsibility for their actions or did not complete the responsibilities associated with their professional role, this is seen in the doctors' quote in Table 16. This theme emerged across all professions who partook in this study. Doctor participants who were observed appeared to be involved in

more frequent interactions that ended in conflict with other professionals. Situations where blame was mentioned commonly involved hierarchy, roles, following incorrect procedures and poor management.

Table 16: Illustrative quotes on blame & conflict from interviews and focus groups

Interviews	Focus Groups
Doctor: I'm sure some people think and treat it very hierarchical, very much like a hierarchy, I have another example where I was asked to intervene because someone thought that the doctor looking after the patient had missed something and I went and said have you considered doing this? And when he found out that I had been asked to look at the x-rays by one of the physios he was fuming. And he was really angry and he was saying 'well if they ever, ever interfere with my management again I will… oh I don't know what he said but he was quite, he was furious.	*Administrative staff: No this lady who transferred in February. There was this (x CEO) did not approve. Not in writing but verbally approved. So we had to contact the education people, she was transferring to education department, and then they were pointing fingers at us saying we should have done Phase 1 which is to transfer her out. But we don't do it without proper documentation. So this person was caught because we couldn't do anything and they couldn't do anything but when there was a problem, we had to put the CEO in the fray because he's the one who created all this problem. When he spoke to the HR person, there was this conflict because he said he could not discuss matters with a subordinate which was the HR person. He wanted somebody at the same level as him.*

The theme of responsibility was mentioned by all participants; as a noteworthy influence on communication, as it appear to affected health care workers when other staff did not take responsibility for their actions. Professionals need to be accountable for appropriately completing tasks delegated to them, being competent in their professional knowledge and should receive and provide adequate supervision in their work environment (NHS, 2012).

A quote that reflects common issues surrounding external responsibility was related in the doctors' focus group (Table 17). One of the doctors in their interview talks about a patient in their ward that needs more services than the district hospital can provide. They keep referring him to tertiary hospitals but he gets sent back. The hospitals may not be able to take the patient for a number of reasons, however the doctor is now in a position where he is responsible for the patient but is unable to do anything more for him.

Table 17: Illustrative quotes on responsibility from interviews and focus groups

Interviews	Focus Groups
Doctor: I think it has a lot to do with accountability and people don't feel responsible and nobody's accountable and so when they don't feel like doing something, they don't do it. And I and I think when you try to address a problem there's a lot of lying and there's pointing at other people. What happens a lot and what always frustrates me, for example the nurses in the ward, you see your problem and you want to communicate about it and say look this is the problem la la la la la and you expecting a solution. Let's make a solution but the first thing they say is wasn't me, it was the person from last night or it was the person from yesterday and it's never them. And I don't know if they communicate between each other but it's not getting better there's still a lot of it wasn't me.	*Doctor: We shouldn't be political, there's a patient that's been for palliative care for lateral tibia tib-fib fracture and head injury and um we sent him to X hospital for a CT brain and was sent back to us after they said no the brain scan is fine. But we can't do the (op) for him, we sent the patient to Y hospital now for attention for his fractures. They didn't, they sent him back saying because of the neurological problems they're not going to operate on him now. We can't if they can't we can't. So this guy is stuck with us. I think it's frustrating for us and also for the patient and I think we are opening ourselves up for litigation uh if this guy ever walked again he would remember the period he was not attended to. I don't think the communication has been given to him. We couldn't tell him 'hey look nobody wants you' so we've kept it hoping he will become better and those are the challenges that we experience.*
Nurse: It's poor, because sometimes you will need something or the patients need something that must be done but when you go to that person you find that that person will refer you to someone else.	

A second example of responsibility was described in the previous critical incident where one of the doctors was not taking responsibility associated with his job which led to conflict with his colleagues.

Other examples of poor responsibility mentioned by the participants included not arriving on time, not seeing a patient but referring them to a colleague, leaving work early, not answering the phone, doing ‘the bare minimum’, not helping colleagues when needed and task incompletion. Not taking responsibility in one’s job can be due to burnout and can result in burnout in co-workers. Participants commented that in the rural setting doing one’s job was not enough. Doing more than one’s job due to staff shortages and high caseloads was the norm. Staff who did not go beyond their responsibilities were viewed as selfish and lazy.

SECTION D

'The way forward'

This theme is not part of the systemic and interpersonal categories but rather participants' reflections during their interviews and focus groups on the future of the hospital and the potential way forward. Table 18 includes some of the participants' strategies that they believe would benefit the hospital.

Table 18: Illustrative quotes on intervention from interviews and focus groups

Interviews	Focus Groups
Management: We have a lot of potential because we don't have a private hospital nearby. If we can open some private wards here which will attract the specialists, that they can come and see their patients here and it will enable us to us them for also our patients. If we can try and get enough funds so that we can open more wards, private wards and we can be able to tap into the wise of the specialists that will be attending those wards.	Administrative staff: Maybe by educating the staff or workshops, teaching the staff about conflict and how to handle the conflict.
Allied staff: We can make communication better by acknowledging each other's professions, and knowing more about the other person, the other professions around the hospital.	

As previously discussed in the NHI section of the systemic results, the NHI results illustrate the anxiety of healthcare workers about their future and upcoming changes to

their work environment and service provision. Participants are hopeful for the future but, as previously described, are sceptical of the implementation of a new health system. The majority of participants envision a future with better services that engage more within the community. Participants mentioned types of interventions that they believed would improve their interactions as well as the services that they provide. Interestingly, all of the interventions that participants mentioned are relatively inexpensive and could be implemented at a provincial or national level. These interventions include training and workshops, meetings, supporting interprofessional collaboration and attracting skilled health professionals to the area. Participants noted that workshops and training should focus on orientation, communication skills and understanding the roles of other professionals. These interventions would then be further supported by multidisciplinary meetings and interprofessional interactions.

Attracting professionals was seen as one of the greatest challenges and a challenge which will surface again with the introduction of the NHI scheme. Staff mentioned that the following strategies would attract skilled health care workers:

1. Placing skilled staff in rural areas for their community service year
2. Providing more provincial bursaries for health professionals, especially to local community members
3. Encouraging interprofessional and rural exposure at a tertiary level
4. Providing monetary incentives for rural health workers

Only two professional specific groups had different thoughts on intervention and the future of the hospital. The first group was the doctor participants who mentioned the need for workshops and training. However they noted that the biggest change that needed to occur was in staff attitudes. The need for individuals to take responsibility for their actions and be accountable was the greatest attitude that the doctor participants felt were needed. Yet when these participants were asked what could be done to improve this they felt that inventions would have little or no change in this area.

The second group that envisioned a different future for the hospital were the participants who represented management. What was surprising about the two participants that represented management was that they both had a firm and in-depth understanding of NHI yet their future of the hospital included privatization of part of the hospital. These participants believed it was crucial for the future of the hospital to have some private wards for two reasons. Firstly, they noted that patients will always prefer private care if they can afford it and secondly, private wards will attract specialists and these specialists could be utilized to aid government patients too. This future reflects the faith or lack of faith that management sees in NHI.

Another common result that emerged from all the participants was that many of their experienced challenges are linked to the fact that this is a rural hospital. Therefore, when they were speaking about the future they noted that they will probably still have challenges such as limited resources and staffing shortages as a result of being a

hospital within a rural area. This is an important aspect to acknowledge as health care intervention needs to be specific to the needs of the staff and physical isolation due to geographic location cannot be changed, this plays a big role in the functioning of the hospital. In addition, it is important to note that there was good correlation between the methods of data collection and no striking divergent findings emerged from the health care professionals' interviews and focus groups, nor the researcher's observations.

Conclusion

This chapter has presented the themes that have emerged from the analysis of the data. The chapter began using Goffman's framework which was found to be not as beneficial in a rural context and therefore other categorise were used to further explore data. The thematic results were organised into the two overriding categories of systemic or interpersonal findings. Within the two main categories numerous themes were described with supporting quotes or account of the observation. Twelve themes were mentioned in this chapter and include: rural issues, the surrounding community, National Health Insurance, support systems, communication, language, management, power, conflict, identity and roles, procedures and referrals. These themes will be explored and examined further in the following discussion chapter.

CHAPTER 6

DISCUSSION

Overview

This chapter explores in more detail factors which influence health care workers communication in their rural health care environment. Four topics were examined and include: a new framework for front and backstage in the rural context, isolation, identity and interprofessional interactions. In this chapter the researcher will describe key discussion points or unique factors that emerged from the results as well as compare the results to current literature.

The aim of this research was to describe and understand interprofessional communication between health care professional in the rural context. While the Goffman's framework (as discussed below) was not found to be as successful in the unique rural South African health care setting this research has meet the 3 objectives that were set out in Chapter 4. This research has provided insight into communication between interprofessionals in the rural setting and has given us further understanding into where important communication occurs in health care. Further, as outlined in Chapter 5 interpersonal and systemic factors that influence communication were able to be identified.

Adaption of front and backstage for rural health care

Goffman's framework was not as successful in understanding interprofessional communication in a rural context as anticipated. Goffman's front and back stages with Lewin and Reeves' (2011) additional planned and unplanned areas are helpful in understanding parts of communication observed in the rural setting; however in the rural context the front and backstage are not clear and the boundaries are often blurred. Goffman's adapted framework was found to be beneficial when examining aspects related to unplanned back stage as it showed how both formal and informal communications between interprofessionals are crucial. Lewin and Reeves' (2011) research and Goffman's theory highlights that communication intervention should not only target the front stage of communication.

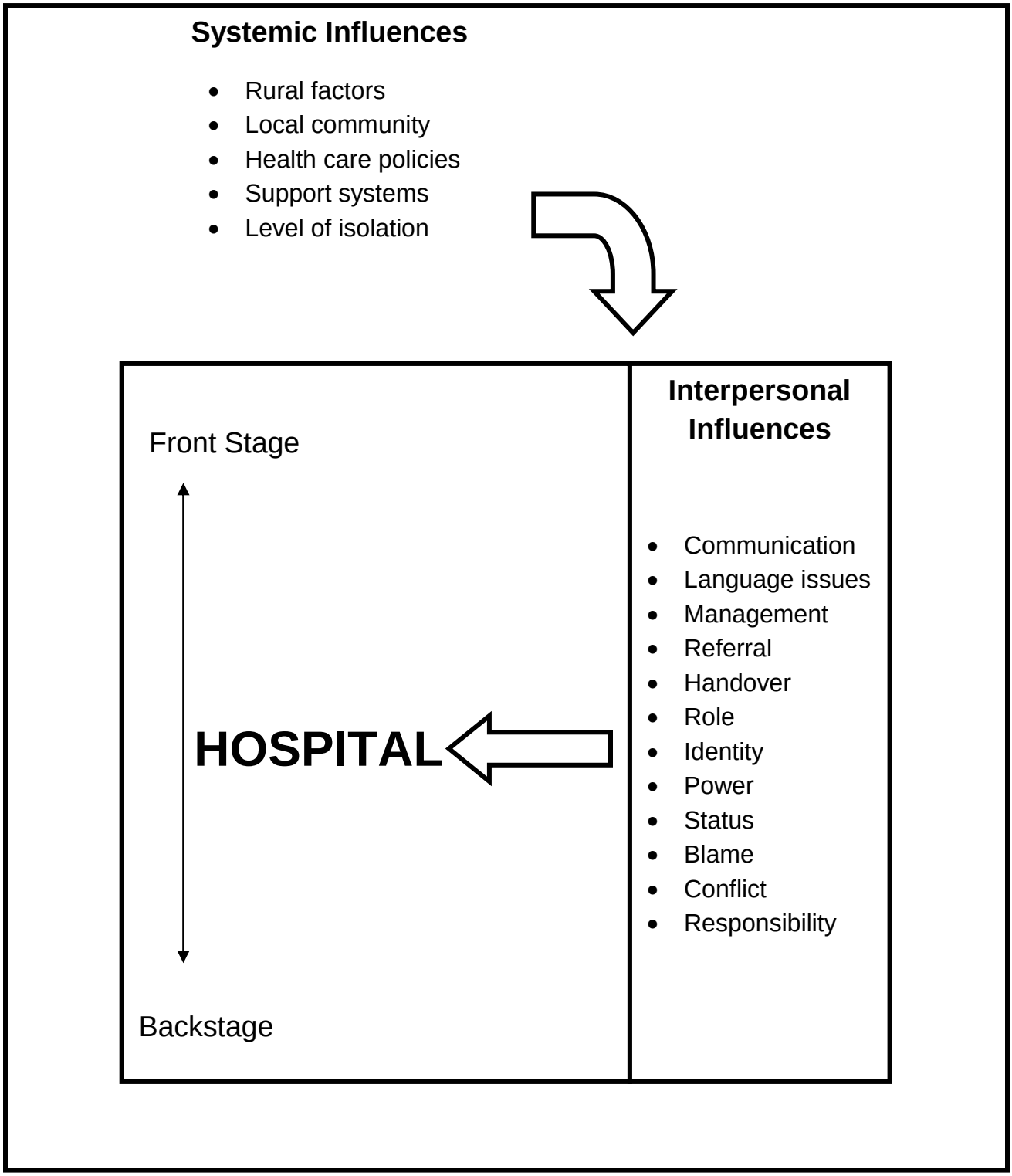
Goffman's division of space where interactions occur brings our attention to the importance of the use of space. Hospitals are generally designed for function (Solheim, McElmurry & Kim, 2007). Open planned space allows for professionals to monitor patients and observe without intruding. Yet this study highlights the crucial need for private spaces for the development of back stage communication.

From the results of this study and the acknowledged importance of systemic and interpersonal influences on interprofessional communication, the researcher developed a model for understanding the complex communications that occur between health care workers in the rural setting. Figure 8 includes part of Goffman's front and backstage

aspects as well as the numerous influences on communication as identified in this study. Instead of additional areas of communication such as those suggested by Sinclair (1997) or Lewin and Reeves (2011), front and backstage in this model is viewed as a continuum. This continuum is advantageous in the rural context where unclear boundaries between the front and backstage may occur, and this appears to be a unique feature of the rural context. Evidence of this was seen in the critical incident which described the mix of both front and backstage elements occurring simultaneously during the morning meeting with health care workers. As the research results found that backstage interactions are equally if not more useful in understanding interprofessional communication processes, the continuum therefore aids in classifying an interaction as front or backstage but also allows for interactions to be classified as the in-between stage.

By applying eco-social theories perspective of viewing both the individual and contextual systems, systemic and interpersonal themes were used to further understand the communication between interprofessionals in this research. Figure 8 further shows how systemic influences play a role in affecting both the front and backstage as well as interpersonal communication. Systemic influences, which were found to be most influential from this research as they also impact interpersonal factors and from the literature in chapter 2, were found to include rural factors, relationship with the local community, isolation, current health care polices and the available support systems in place for health care workers.

Figure 8: Framework to analyse and understand interprofessional communication in the rural South African health care context



Interpersonal influences that occur within the hospital impact health care workers and the themes that emerged appeared to go beyond just a front or backstage and thus interpersonal influences have been included in Figure 8 as a separate analysis. These interpersonal influences were derived from the results in this study and include communication, language issues, management, referral, handover, role, identity, power, status, blame, conflict and responsibility.

This proposed framework appears to be more favourable for understanding interprofessional communication in the rural health care. While social interactional theory explains some of the barriers to communication in the rural setting it does not account for blurred boundaries and overlaps in communication which were found in this study.

Sinclair (1997) and Lewin and Reeves' (2011) models appear too simplistic to be applied in the rural hospital environment as this research found that front and backstage categories were not clear in the rural environment and numerous other influences were also found to impact the health care workers. The influences that affect communication are not only internally found within this rural hospital but systemic influences appear to have a far more profound effect on communication in a rural context than previously recognised, for reasons which will be explored further in this chapter.

Isolation

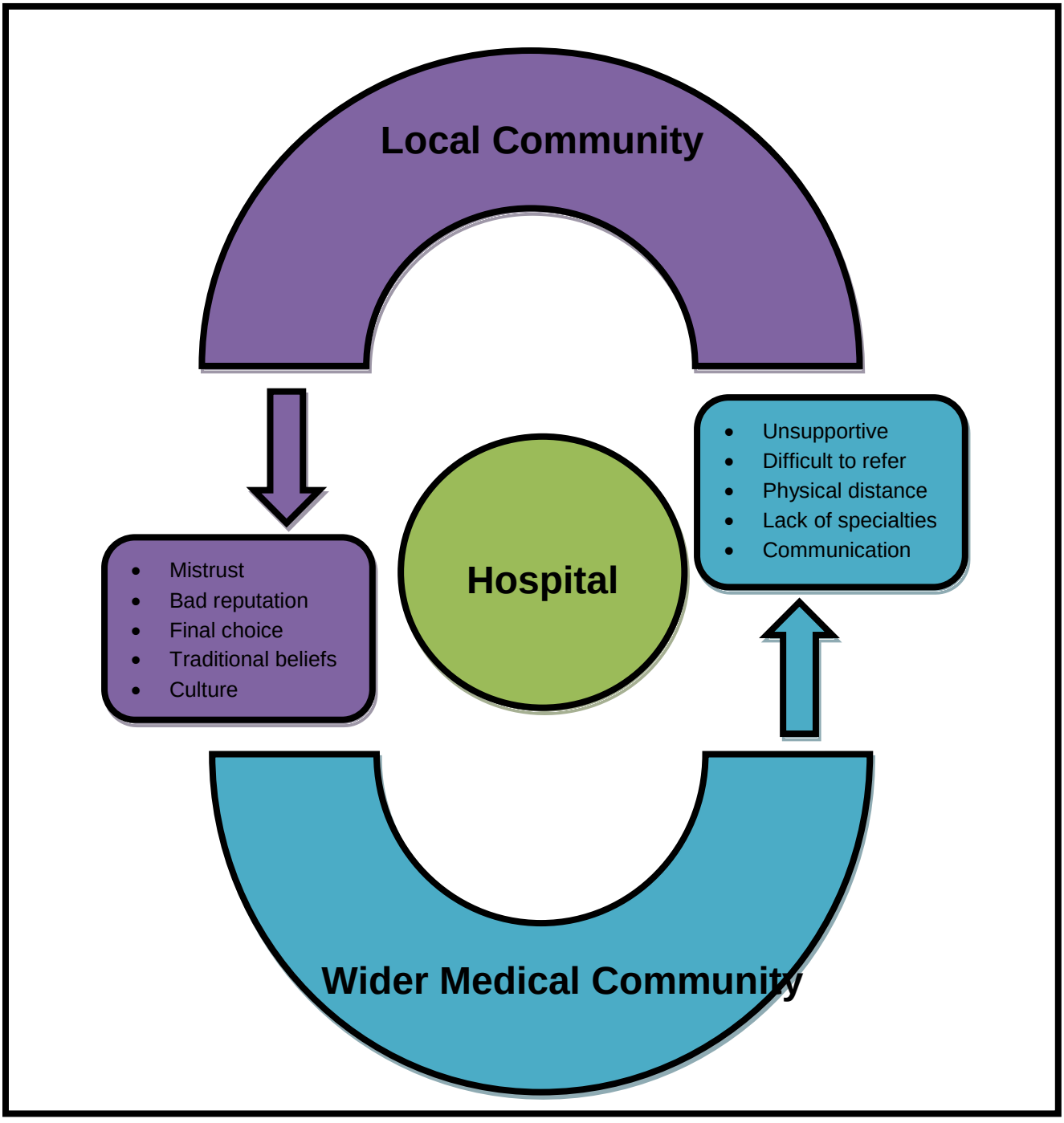
Isolation appears to be a factor that emerged in both systemic and interpersonal themes (Figure 9). There appears to be a dual systemic level of isolation from both the surrounding community and the wider medical community. Health care workers were highly aware of these external forms of isolation and poor communication was often linked to these factors.

From the analyses of the results is appears that there is limited communication between the local community and the hospital. Health care workers reported that their sense of isolation from the community was largely due to socio-economic issues and opposing world views. This has been reported on in other studies (Chipp, et al., 2011; Levin, 2008). Participants felt frustrated with trying to bridge the gap between what the community believed about health care and what the health care workers felt the community should know. Chipp et al., (2011) wrote about the influences of the rural environment in health care and commented on the challenges associated with building community relationships. The researcher found that the community did not appear to trust the health care workers and the services they provided and clear channels of communication were recommended to improve this situation. Further the medical facility should become aware of the community's diversity and strengths so that the community can build relationships and trust in the health care facility (Ricketts, 2000).

The location of the hospital does isolate health care workers geographically as they are not near a city or other supportive medical facility. When participants discussed the differences between rural and city hospitals a common response from the health care workers was that rural facilities often lack adequate resources and professional specialists. As van der Geest and Finkler (2004) argue in their article on hospital ethnography, it is questionable whether a hospital is part of the surrounding community or whether it is an island within the community. In this study is appears that the hospital acts as an 'island' cut off from the surrounding community in which they live and the broader medical community.

This aspect of the results was surprising to the researcher as when the researcher had worked at the hospital a sense of isolation was not identified which may have been due to having built up relationships within the hospital. Viewing the hospital now from an outsider's perspective allowed for a bigger picture to emerge. What did emerge strongly was the difference between the insiders versus the outsider's perspectives. One example of this is the 'negative' communication process was where an individual in the hospital was not greeted due to status or profession.

Figure 9: Systemic factors that influence isolation



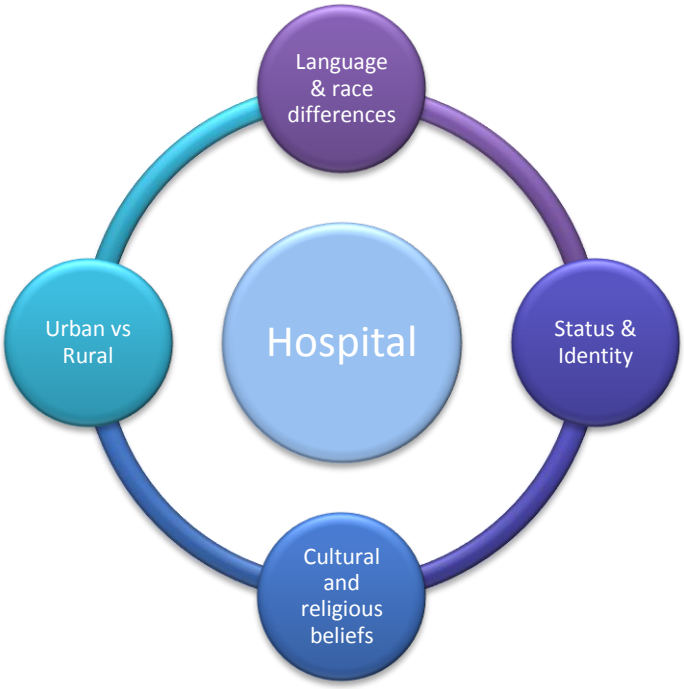
To insiders working within the hospital this example may appear ‘normal’ however to an outsider this type of ‘negative’ communication appears as ‘abnormal’ communication

interaction. This difference in perspective further examples the researchers surprise at some of the results.

When dealing with more severe medical patients health care workers were required to refer patients to a more appropriate medical facility. It is in the participants' discussion of referrals that isolation between this rural hospital and supporting medical facilities was described. Health care workers felt unsupported and alone in their responsibilities. It was further mentioned in the doctors' interviews and focus group that they felt their requests for referrals at times were not taken seriously as the other referral hospital either did not trust the doctors referral or that they were just pass off their workload. Health care workers also had limited means to communicate with the outside world. Participants only had telephones and limited internet access.

While there were numerous factors contributing to the health care workers feelings of isolation it was the internal interpersonal aspects which appeared to be most apparent to participants. The lack of support systems seemed felt by participants most when more than one factor of isolation was impacting on a participant.

Figure 10: Interpersonal factors that appear to lead to isolation at the hospital



Interpersonal isolation was observed by the researcher, as noted in Figure 10. Often teams or groups in the hospital would form based on the characteristics of the group. Groups and teams often form when individuals have common backgrounds and interests (Mickan & Rodger, 2005). The four areas in Figure 10 are characteristics that divided health care workers into set groups. The first and most obvious is status and identity, health care workers at the hospital appeared to group with those of a similar profession and of equal status in the hospital. Language and race further impacted on group division where participants of the same race and language would be more likely to interact and form working relationships, this was similar with culture and religious beliefs. Another grouping that was observed by the researcher was the grouping of urban participants and rural participants. In this category different professionals would

interact based on similar backgrounds, this was observed with urban participants who were doctors, allied staff and management.

As in most work environments, health care workers at the hospital formed tight-knit groups (Keyser, 2009; Mendes & Stander, 2011). Grouping seemed to occur according to a number of factors including: race, language, religion, profession, background and status. While this is not unique due to the systemic isolation, especially geographic isolation, the effects appear to be more evident in the health care workers' lives and it affected working and social relationships. Another factor which could contribute to the interpersonal aspects of isolation may be nationality, with half of the medical doctors working at the hospital being non-South African citizens. The research literature notes that foreign doctors may have difficulty in adjusting to new cultures and a new environment (Wilson, et al., 2009), however in this study the only difficulties mentioned were those related to language.

Although the effects of isolation on rural health care workers are not well known, this study gives insight into some of the challenges of internal and external isolation. In this rural hospital it appears that isolation affects the health care workers and their work environment on a daily basis. Therefore in the South African context it is important to consider the influence isolation has in the health care setting and on health care workers. It is possible that isolation may put rural health care workers at a higher risk for burnout and may be linked to poor staff retention. Staff retention may be an additional

contributing factor to isolation at the hospital as permanent staff may feel reluctant to build relationships with health care workers who may not stay on for an extended period of time.

Factors that are related to rural health isolation have been noted in research including lower support systems, loneliness, depression and burnout. Keshvari (2012) noted 6 themes in burnout including instability and changes, poor regulations, unbalanced workload, helplessness in performing tasks, threatened sense of identity and deprivation of professional development. From these themes it appears that participants in this study may be at high risk for burnout. Reasons for this potential risk include that the hospital staff appeared concerned over the uncertainty of NHI scheme, staff shortages may increase caseloads, the hospital has a definite hierarchical structure as well as poor role identity and health care workers appear to have limited opportunities to access training or skills development. Further a sense of helplessness was noted in the results and can be seen in some of the illustrative quotes. Rural health care workers need to practice good self-care to avoid burnout (Chipp, et al., 2011) yet there appear to be no coping strategies implemented by the hospital or encouraged by health care workers in the study. These participants who appear to be at a high risk for burnout may put less effort into their communication with their work peers and may appear more affected by poor communication within the hospital (Delobelle, et al., 2010).

Identity

Identity within the hospital may be related to issues surrounding interprofessional communication. There appears to be an unhealthy sense of identity found within the participants in this research which seems to manifest in two different extremes. The first is that some professionals only communicate within their own professional group to the exclusion of other groups, this was observed with nursing participants who did not often refer and were reluctant to initiate interactions with other health care workers. This behaviour could be attributed to an individual or group feeling threatened by another group, possibly related to factors such as power dynamics, conflict in the work environment, blame, high workloads and stress.

The second potentially 'abnormal' behaviour related to identity that was observed in the professionals were those who went beyond their professional boundaries. These professionals felt comfortable taking on the role of other health care workers when they were not available such as allied staff changing a patients bedding. Linked with the systemic factors, the rural setting of the hospital may largely impact on why professionals were going beyond their boundaries. Staff shortages and huge caseloads may require an aspect of task shifting. As seen in Watermeyer (2012) study, task shifting can occur successfully between professionals when they are secure within their professional identity. However the results of the current study appear to suggest that identities are not secure and roles are not well understood. This was further seen in the

analysis of the hospital interactions using Goffman's framework where interactions were not clearly front or backstage in nature.

Interprofessional communication within the hospital

As discussed in chapter 2, there are a number of requirements to accomplish interprofessional teamwork and some of these requirements were commented on by participants in the study as areas that needed to be developed. Watermeyer's (2012) study looking at a successful clinic found that for good working relationships within teams to occur, interactions between health care workers need to be based on elements such as mutual respect, trust, understanding and friendship. One of these factors affecting interprofessionalism is knowledge of other professional roles which participants in the study reportedly felt they did not know or that other professional groups did not understand the professional boundaries. While participants appeared to be willing to participate within interprofessional teams, interpersonal and systemic factors appeared to influence the health care workers' motivation.

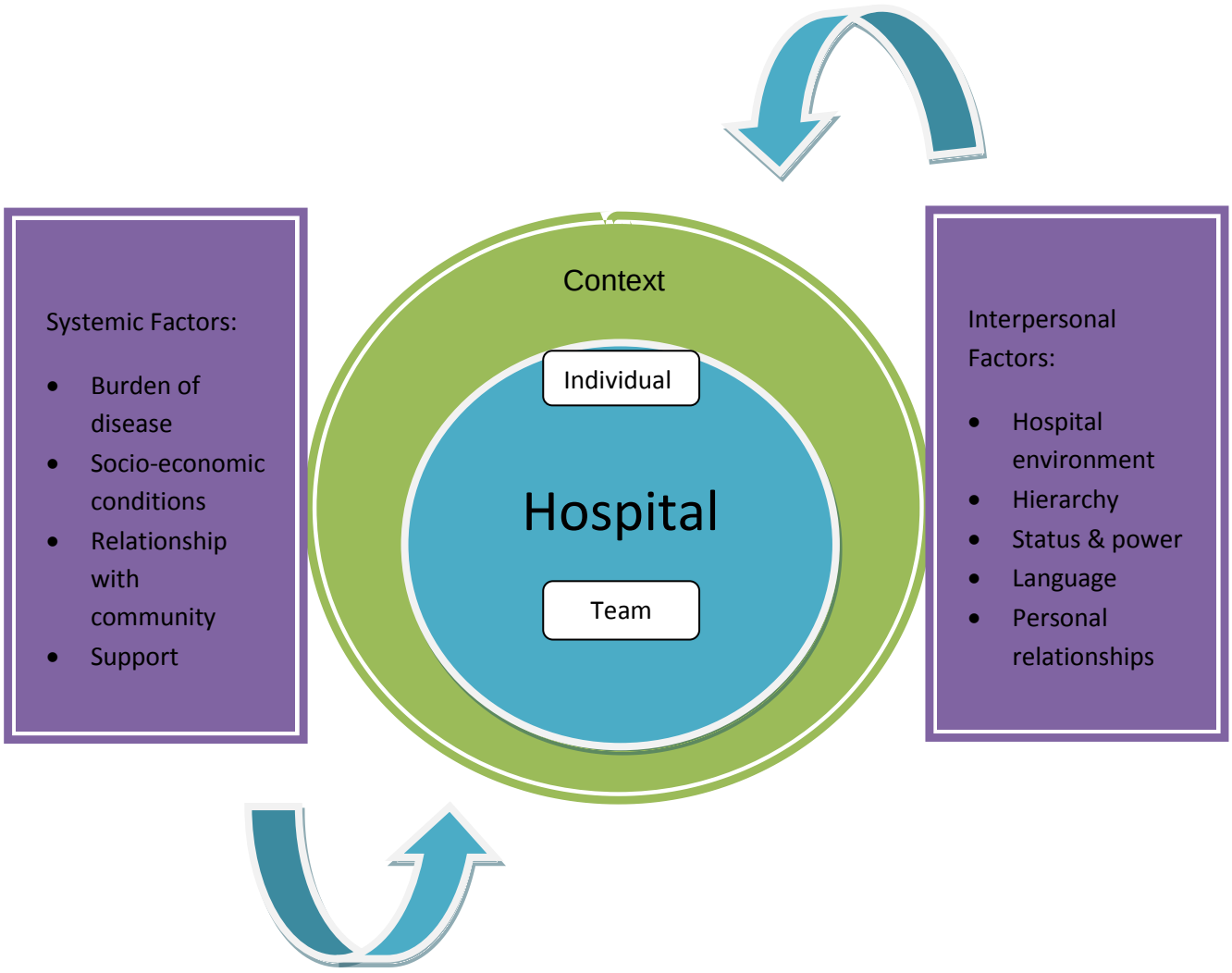
Communication channels within the hospital seemed particularly hierarchical and did not appear to be transparent. This was evident in this study with information regarding the NHI scheme where management acted as 'gatekeepers' of information which may be linked to their status and power being at the tops of the hospital hierarchy. Mutual trust and respect was evident between some health care workers however this was not universal across all of the health care workers in the hospital. Shared power based on

hierarchical relationships is noted in the literature as central to interprofessional function (Harle, Page & Ahmad, 2010), yet this may not be realistic in a rural environment where health care workers' power and status within the hospitals is also linked with income. All these factors appear to contribute to poor interprofessional communication within the hospital.

An area that participants appeared to feel strongly about was receiving more input and support from senior management to aid in conflict resolution and reducing barriers between professionals. Additional support would further benefit health care workers to reduce stress and may increase retention of staff (Barrett & Keeping, 2005). The hierarchical structure within the hospital creates barriers, which were observed between health care workers. Management did not appear to assert themselves within the health care workers' daily routines and were only visible during meetings. It seems that the health care workers need more structure and guidance in their work environment. In this setting where health care workers have limited support structures, clear leadership seems needed to establish clinical organisation and routines. By having set routines health care workers will have a more supportive environment and health care workers within the task/activity may be able to understand other professionals' roles and responsibilities as they will be defined within the routine. Organisational routine also provided a sense of security and decrease anxiety for health care workers (Crawford & Brown, 2011).

Figure 10 illustrates the importance of context for communication for both the individual and the team (Bateman, 2012; Delobelle, et al, 2010). The figure shows how interpersonal and systemic factors influence the hospital environment and thus influence the health care workers and their teams. Health care workers within this environment continually experience these influences and some interactions may be affected by these factors such as nurses who live in the community but are not necessary acknowledged by their community as health care workers.

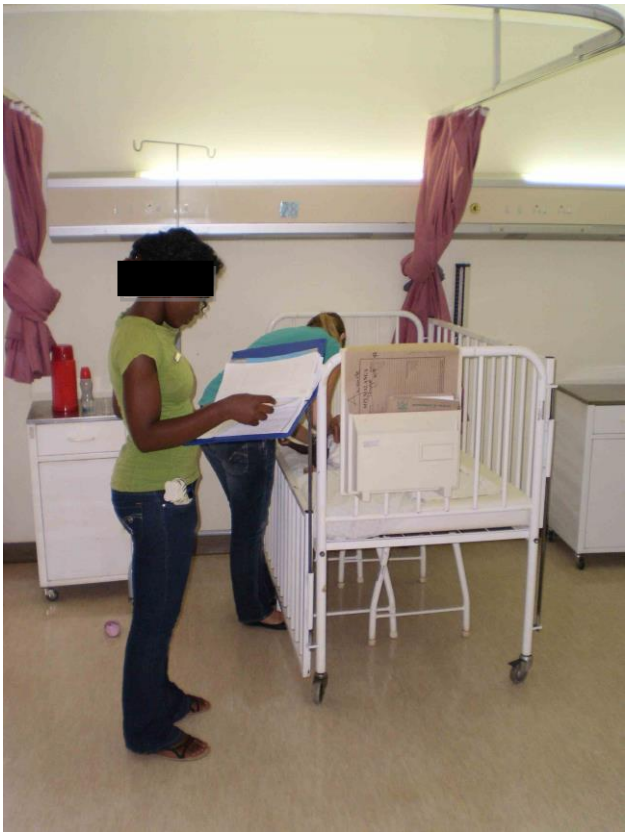
Figure 11: Interpersonal and systemic influences on interprofessional communication



Interprofessional work in the health care environment relies on all members taking accountability for their actions (Dow & Evans, 2005). In this study the theme of responsibility appeared to affect health care workers on a daily basis. This was usually seen when a colleague did not complete a task or completed a task incorrectly, which further led to conflict. Due to the hospital's rural context and having reduced staff available, the impact of poor performance or lack of responsibility appeared to affect rural health care workers more than their urban peers. Delobelle, et al (2010) found that rural health care workers have higher levels of stress and less support systems than their urban peers. As seen in the results of this study participants felt that the rural health care environment lacked the same opportunities as an urban hospital such as specialists, resources, training and communication methods like internet.

The most common style of communication which was observed between health care workers was parallel teamwork. Photograph 8 shows how two different professionals in the hospital use parallel teamwork. While this approach to teamwork may be beneficial for the health care worker and patients (Mickan & Rodgers, 2005), the health care workers do not collaborate to reach a set goal nor do they need to understand the other health care workers scope of practice. It appears that professionals within the hospitals do not use conventional interprofessional collaborations such as multidisciplinary ward meetings or regular follow up.

Photograph 8: Parallel teamwork



The breakdown in interprofessional communication may be related to a number of issues. The first of these potential influences is systemic and interpersonal isolation, health care workers may feel that due to their high workload tasks need to be completed as soon as possible and dealing with other professionals can be time-consuming. Power and status further contribute to poor interprofessional relations as power struggles and hierarchy affect potential relationships between health care workers (Solheim, McElmurry & Kim, 2007). The micro-environment is often a reflection on the larger macro-environment (Darling, 2007; Levin, 2008). The community that lives in the Nkomazi district is isolated from the rest of South Africa. The community has strong traditional beliefs, receives limited resources and support from the government and

conflicts within the community are often dealt with internally, and these aspects can be seen within the environment of the hospital.

For successful interprofessional interactions and teamwork conflict need to be managed and dealt with appropriately (Kenward, 2011). In the hospital it was observed that conflict occurred in short bursts usually with shouting and banging of objects. Once the initial argument concluded it was not mentioned again and health care workers did not appear to dwell on the negative interaction. This may be a possible coping strategy; however it does not appear to be constructive and may further damage interprofessional relationships. For successful team work shared goals, shared knowledge and mutual respect needs to be established within the team (Haven, et al., 2010). However it does not appear that these features are present between participants at the hospital.

The most unique feature of this research is that even though the hospital appears to have poor professional identity, lack of support structures, and a sense of isolation the hospital still appears to be functioning well as staff continue to work at the hospital and services are maintained. It seems as though the staff at the hospital accept the barriers that they face on a daily basis and have become so accustomed to the environment that they themselves do not see the full extent of the challenges that they face. Health care workers in this environment have adapted and some even thrive within the setting. Health care workers do not appear to notice all of the challenges and ‘abnormal’ interactions when they are in the environment however from an outsider’s perspective

the communication, interactions and behaviours may appear strange. To aid health care workers awareness of ‘abnormal’ communication reflective practice could be used to identify problem areas. Secondly health care workers should continually review their team goals for their own interprofessional interactions as well as their patient goals.

Conclusion

This chapter has looked at communication in the hospital according to Goffman’s front and backstage as well as Lewin and Reeves’ (2011) additional planned and unplanned areas. It was found that there were no clear distinctions between the front and backstage which may have been linked to the lack of private space for health care professionals. The potential systemic and interpersonal factors that influenced the hospital’s sense of ‘isolation’ were explored, and the theme of isolation appears to play a large role in interprofessional communication. Aspects of professional identity and interprofessional communication within the hospital were discussed.

CHAPTER 7

CONCLUSIONS & FUTURE IMPLICATIONS

Overview

This final chapter outlines the potential implications of this study and identifies the key elements for research in the field of interprofessional communication in South Africa. The researcher has also included a brief reflection on her experiences.

Implications & Recommendations

Little is known about the effects of the rural setting on interprofessional communication in South Africa. This study adds knowledge to this field and develops new research questions for future exploration within the rural hospital environment. This study further adds to South African specific theoretical literature in health care by providing a systemic and interpersonal framework, and a potential framework for examining different areas of communication. Adding to knowledge of the healthcare system is significant as South Africa's health system is currently in the process of implementing National Health Insurance which aims to provide better access to services for all South African citizens.

1. **The move to promote interprofessional communication at a tertiary educational level**

Previous research has demonstrated the benefit of interprofessional communication for hospital staff (Hean, et al., 2006; Gardezi, et al., 2009; Havens, et al., 2010; Brown, et

al., 2011; Kenward, 2011; Rose, 2011). This study further confirms that health workers acknowledge the importance of interprofessional communication and feel that it should be promoted, encouraged and modelled throughout tertiary training institutions in South Africa. This would allow students in health professions the opportunity to practice these important skills before entering the work environment, for example promoting more natural/intuitive communication and introducing efficient interprofessional communication as a core work standard.

2. Promoting community health education

The disconnection between the community and the hospital is a strong theme noted in this study. Feedback indicated that the community were dissatisfied with services and the hospital staff reported frustration with the community's health seeking behaviours. An educational intervention is recommended at a community level, in collaboration with community leaders, in order to maximise health care provision, identify areas of strength and areas of improvement. An intervention at the community level should include communication and education regarding seeking appropriate services, opening channels to engage with the hospital and patient health education.

As part of any engagement with the community, it is essential that the health service provider, in this case a hospital, remain open and transparent to facilitate the communication process. The hospital may use the opportunity to acknowledge areas of service delivery to improve on, such as waiting times. This may serve to educate and empower the community to collaborate with the hospital to improve service satisfaction.

3. Developing policies

New policy development should always be guided by recent and relevant research. The results of this study may be used in such a manner in light of the rollout of the pilot of National Health Insurance across South Africa in 2012 and 2013. The information that this research provides regarding the perspectives and experiences of health care providers is relevant to the context of the NHI. In addition, the results of this study may contribute to knowledge for policy development in interprofessional teamwork, training and context specific issues. The results from this study may further aid in the development of policies regarding communication in hospitals in South Africa by providing a more appropriate framework in which to study communication.

4. Indications for future research

Research into interprofessional communication and rural experiences of health care workers is new in the South African context and the results of this study have thus brought up a number of new research questions. As this study was completed in one rural hospital, future research could focus on other rural hospitals across South Africa, specifically focusing on the impact of context on communication. A comparative study of interprofessional communication at urban and rural hospitals would add insight in this emerging area of research. The critical incident for example showed how conflict in the health care setting can emerge during meetings.

5. **Training programmes**

The results of this research have the potential to be used to develop rural hospital training programmes that focus on facilitating effective and efficient interprofessional communication. The results of this study also highlighted the potential need for programmes and workshops that target role identities, conflict resolution and team building. The hospital where this study took place has already used some of the findings as motivation for training and development grants as an active measure to improve various skills in the hospital. The study further acknowledges the use of drama techniques as a potential intervention strategy.

6. **Support structures**

One of the most important findings to emerge from this study is the need for support structures for rural health care workers. Ideally, support structures should be both internal within the workplace and externally such as from the province. The development of support structures such as mentoring and regular support meetings would aim to address the themes of isolation, identity, responsibility and blame that came through in the study.

7. **The role of the communication specialist**

Communication is critical for the successful implementation of new health care legislation and speech-language therapists have a potentially important role to become centrally involved within the changing system, not only as health care professionals but with a role and the skills and knowledge to positively contribute to South Africa’s health

care within a broader framework. Knowledge and skills from this field could for example be used to develop team communication and potential communication training programmes according to the specific needs within the environment that they work and interact in.

8. Theoretical implications

The findings of this research has shown that Goffman's front and backstage are useful in understanding communication in the rural context however it is not sufficient enough to provide a comprehensive picture and therefore eco-social theory's systemic and interpersonal feature aid in providing a more holistic understanding. Future research should look at identifying a model that can be used in the South African health care setting that fully comprehend these interactions across professionals.

Limitations

The greatest limitation and potential bias within this study has been identified as the researcher's previous work relationship with the hospital at which the study was conducted. However, as mentioned within the methodology chapter, this was a recognised strength and limitation and thus was monitored and scrutinized throughout the research period. While this study provides important insights into interprofessional communication at a rural hospital, this also serves as a limitation. The results of this study report on only one context of healthcare communication and thus South Africa's diverse social-cultural environment may mean that the application of the results may be limited in other contexts or in reproduction of this study. While this is a recognised

limitation, it serves to highlight the importance of providing support, training and development at an individual hospital level. A final limitation within this study is that the study did not explore or compare interprofessional communication within urban hospitals, thus some presumed unique rural factors may also apply in an urban context.

Site-specific recommendations

Site-specific recommendations have emerged from the data. The hospital management were given recommendations regarding three key areas. The first recommendation was to create a platform in which the community and the hospital can communication effectively. The second recommendation was to promote interprofessional communication within the hospital that was supported by management and that communication training was provided where necessary. The third recommendation was to establish support structures for health care workers both within their department and within the hospital as a whole.

Reflection on the research process

This research process over the past year has been simultaneously exciting, challenging and rewarding. Having completed my community service year at the hospital and lived on the hospital grounds, I do not feel I took the time to recognise and process my experiences and challenges at that time. Listening to the participants' stories as I collected data, the themes and experiences that they reported resonated with me and

provided the opportunity for me to explore and reflect on my own experiences in a new light. Before starting the research, I thought I had a good idea of what the results would reveal, based on my previous experiences at the hospital, yet I was still surprised about many of the reports and findings. While I knew of the varied communication that exists within the hospital and having personally dealt with many of the rural challenges, I think my view of the hospital was influenced by my defined exit date at the end of my community service year.

Looking back on the experience I would not have changed my topic but I would have focused on a more specific area like a ward or theatre to narrow the scope. The methods that I used yielded huge amounts of data and having semi-structured questions in the interviews and focus groups allowed for participants to share their personal experiences and views. If I was to repeat the study I may not use vignettes as they were not beneficial with all of the profession-specific groups or I would adapt the vignettes and use a video example instead. I found parts of Goffman's framework particularly helpful when analysing and classifying interactions that were reported and observed, however it did not allow for in-depth analysis in the rural context. The most surprising aspect of this research was how differently I viewed the hospital when I had an 'insider' perspective versus an 'outsider' perspective. In retrospect I think that when I was working at the hospital I did not see the challenges as they appeared to be norms within the environment. In the future I hope to explore the topic of interprofessional communication in more depth and in different settings. This research has not only

helped me grow as a person and within my academic field but it has developed my passion for rural health care.

Conclusion

Past research confirms that interprofessional communication improves the quality of medical services and employee satisfaction. The results from this research illustrate the importance of understanding both systemic and interpersonal factors that affect communication for rural health care workers. By using Goffman's framework of front and backstage this research was able to acknowledge the significance of communication for health care workers in both stages. Speech- language therapists need to establish their role as communication experts and aid in improving interprofessional teamwork and training effective communication.

Allied Staff: *"We can do better for our patients; we want to be better for ourselves. We are here to help and despite the challenges we face every day we wake up the next morning and start all over again."*

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APPENDICES

Reference List

Appendix 1 – University of the Witwatersrand Ethics Approval

Appendix 2 – Mpumalanga Department of Health Ethics Approval

Appendix 3 – Approval letter from Hospital's medical manager

Appendix 4 – Information letter for Hospital

Appendix 5 – Information letter for participants

Appendix 6 – Informed consent for participants

Appendix 7 – Informed consent for audio recording of participants

Appendix 8 – Focus group questions for admin staff

Appendix 9 – Focus group questions for allied staff

Appendix 10 – Focus group questions for medical staff

Appendix 11 – Focus group questions for nursing staff

Appendix 12 – Interview questions for administrative staff

Appendix 13 – Interview questions for health care staff

Appendix 14 – Profile of the research assistant

Appendix 1 – University of the Witwatersrand Ethics Clearance

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Ms Caitlin VK Longman

CLEARANCE CERTIFICATE	**M120334**
PROJECT	Interprofessional Communication in a Rural Hospital: A Qualitative Study
INVESTIGATORS	Ms Caitlin VK Longman.
DEPARTMENT	Speech Pathology and Audiology
DATE CONSIDERED	30/03/2012
DECISION OF THE COMMITTEE*	Approved unconditioally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 30/03/2012 **CHAIRPERSON** .....
(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable
cc: Supervisor : Prof Claire Penn

DECLARATION OF INVESTIGATOR(S)
To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

Appendix 2 – Mpumalanga Department of Health Ethics Approval

MPUMALANGA PROVINCIAL GOVERNMENT

Building No.3
No. 7 Government Boulevard
Riverside Park Extension 2
Nelspruit
1200
Republic of South Africa

Private Bag X 11285
Nelspruit, 1200
Tel: 013 766 3429
int: +27 13 766 3429
Fax: 013 766 3458
int: +27 13 766 3458

Office of the HOD

Litiko Letemphilo | Umnyango WezaMaphilo | Departement van Gesondheid

Enquiries: Mr M.T. Matlou
Chief Director: Integrated Health Planning
Tel: 013-766 3293

MPUMALANGA PROVINCE
HEAD OF DEPARTMENT
PRIVATE BAG X 11285 NELSPRUIT 1200
2011 -01- 30
RECEIVED
DEPARTMENT OF HEALTH & SOCIAL SERVICES

Ms CVK Longman
[redacted]
2195
JOHANNESBURG

Contact Number: [redacted]
Email: caitora@gmail.com

Dear Ms Longman,

RE: APPROVAL TO CONDUCT RESEARCH ON INTERPROFESSIONAL COMMUNICATION AT [redacted] HOSPITAL WITHIN MPUMALANGA DEPARTMENT OF HEALTH AS PART OF REQUIREMENTS FOR MASTERS IN SPEECH PATHOLOGY

1. The Provincial Research and Ethics Committee hereby grants approval for your research project in principle, provided that you supply the Department of Health with your Ethical Clearance from the University of Witwatersrand, Johannesburg.

2. It is noted that the research will be conducted as part of your Masters Degree of Arts in Speech Pathology on "*Inter-professional Communication at an identified Rural Hospital*" i.e. [redacted] Hospital in the form of interviews and focus groups with willing participants. The purpose of your research is to establish how communication impacts on working relationships and how communication between professionals, impacts on patients. The results of the study will identify barriers in order to develop possible training programmes to target identified issues.

3. No issues of ethical consideration were identified.

RE: APPROVAL TO CONDUCT RESEARCH ON INTERPROFESSIONAL COMMUNICATION AT [redacted] HOSPITAL WITHIN MPUMALANGA DEPARTMENT OF HEALTH: MS CVK LONGMAN

4. The onus lies with the researcher to seek approval from the mentioned public health facility prior to conducting the research.

5. It should be noted however, that the department will be expecting a report on the findings, once the research project has been completed.

Yours faithfully,

ACTING HEAD OF DEPARTMENT
MR M.R. MNISI
DATE: 02/02/2012

cc: Acting Chief Director: Hospital Services: Dr A Shija

Appendix 3 – Approval letter from Hospital's medical manager



Health
Department:
Health
MPUMALANGA PROVINCE

Tonga Hospital
Tonga View
KWALUGEDLANE
1341

P.O. Box 661
KWALUGEDLANE
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Tel: +27 13 7800 222
Fax: +27 13 7800 733

Litiko LeteMphilo | Umnyango WezaMaphilo | Departement van Gesondheid

[redacted]HOSPITAL

To whom it may concern:

Subject: LETTER REGARDING RESEARCH AT [redacted] HOSPITAL

This letter is to confirm that Caitlin Longman has discussed her research project with management at [redacted] hospital. As soon as she receives ethics clearances from the Mpumalanga Department of Health she will be allowed to start her study.

Miss Longman's study is on '*interprofessional communication at a rural hospital*'. Her research will involve interviews and focus groups with willing health professional participants.

Kind Regards,

Dr. [redacted]
Medical Manager
[redacted] Hospital

Appendix 4 – Information letter for the Hospital

SPEECH PATHOLOGY AND AUDIOLOGY

School of Human & Community Development

Faculty of Humanities

University of the Witwatersrand

Private Bag 3, WITS, 2050 Tel: (011) 717 4500 Fax: (011) 717 4559

Information Letter for the Hospital

To: (Medical Manager)

Introduction

My name is Caitlin Longman and I am a speech therapist currently working on my Masters at the University of the Witwatersrand. In 2011 I worked at X Hospital as a community service speech therapist and audiologist. I am looking at interprofessional communication at a rural hospital and how the communication impacts working relationships as well as how communication between professionals may impact patients.

I would like to invite you to take part in this study. It is important to understand communication especially in the rural setting where there are many unique challenges. The study will involve the following:

1. Allowing myself, the researcher and a research assistant access to the hospital so that observations of the hospital can be made. These observations will give a better understanding of the use of communication at the Hospital.
2. Allowing members of staff who choose to participate in this research the time to attend a half an hour interview and an hour-long focus group (approximate

times). A research assistant will be present to allow for discussions to take place in SiSwati. Interviews and focus groups will be recorded with an audio recorder, which only the researcher and her supervisors have access to.

Possible risks

There are no physical risks or invasive tests in the study. Participants will only be required to share their own information and experiences. These results may help us to better understand communication in this unique environment and may help in identifying barriers and creating strategies to overcome them. All ideas will be kept anonymous and confidential. Participants can leave the study anytime they choose to without any consequences. It must be noted that confidentiality during the group discussion cannot be guaranteed but confidentiality will be encouraged within the group. Staff will also be assured that their personal views and experiences will not be fed back directly to management and will not affect their work.

Possible benefits

The hospital will be contributing to research that may improve communication between professionals which will in turn, improve general services in the hospital. Furthermore if the research identifies barriers, training can be developed to target such specific issues.

If you have any questions please do not hesitate to contact me or my supervisors
We appreciate your assistance and time.

Kind Regards,

Researcher
Caitlin Longman caitora@gmail.com
Supervisors
Professor Claire Penn claire.penn@wits.ac.za
Dr. Jennifer Watermeyer jennifer.watermeyer@wits.ac.za

Appendix 5 – Information letter for participants

SPEECH PATHOLOGY AND AUDIOLOGY
School of Human & Community Development

Faculty of Humanities

University of the Witwatersrand

Private Bag 3, WITS, 2050 Tel: (011) 717 4500 Fax: (011) 717 4559

Information Sheet

A Study on Communication in the Hospital Setting

Dear Participants

Introduction

My name is Caitlin Longman, I am currently a Masters Speech Pathology student at the University of the Witwatersrand. I am doing research on health care team communication at a rural hospital. It is important to understand communication especially in the rural setting where there are many unique challenges, and how the communication impacts on working relationships as well as how communication between professionals may impact patients

I would like to invite you to take part in this study.

What is expected from you?

If you agree to take part in this study the following will occur. You will be interviewed individually and a group discussion/focus group will be held with other health professionals. The interview may take half an hour to an hour to complete and the group discussion may run up to an hour. Both sessions may be audio recorded. The audio tapes will be kept under lock and key for 2 two years if research is published and 6 years if not published, after which the tapes will be destroyed as with accordance with

the HPCSA. There are no physical risks or invasive tests in the study. You will only be required to share your own information and experiences. These results may help us to better understand communication in this unique environment and may help in identifying barriers and creating strategies to overcome them. Participation is voluntary and you are free to leave the study at anytime with no repercussions.

During the study you are free to ask the researcher any questions pertaining to the study. Results of the study will be given to participants in the form of a presentation or information sheet.

Your Rights

Only my supervisors and I will look at the information that you provide. Your ideas will be kept anonymous and confidential. You have the right not to answer any question that you do not wish to answer and you do not have to participate in the study. If you do choose to participate, you have the right to withdraw from the study whenever you wish. It must be noted that confidentiality during the group discussion cannot be guaranteed. However to try promote confidentiality group rules will be implemented and participants are not required to answer a question should they feel uncomfortable.

We appreciate you assistance and time.

If you wish to contact the researcher or her supervisors for any questions or queries please feel free to do so.

Researcher

Caitlin Longman caitora@gmail.com

Research Ethics Committee Administrator

Anisa Keshav anisa.keshav@wits.ac.za

Supervisors

Professor Claire Penn claire.penn@wits.ac.za

Dr. Jennifer Watermeyer jennifer.watermeyer@wits.ac.za

Appendix 6 – Informed consent for participants

SPEECH PATHOLOGY AND AUDIOLOGY

School of Human & Community Development

Faculty of Humanities

University of the Witwatersrand

Private Bag 3, WITS, 2050 Tel: (011) 717 4500 Fax: (011) 717 4559

Consent Form

I _____ hereby agree to participate in a study run by Caitlin Longman about communication in a rural hospital.

I understand what is written in this form.

I understand that participation is voluntary and I can withdraw at anytime with no negative consequences.

I understand that the interview and group discussion will be recorded.

I understand that all information provided will be kept private and remain anonymous.

_____

Signature of participant

Appendix 7 – Informed consent for audio recording of participants

Consent form for audio-taping

I, _____ hereby give consent for my interview and my involvement in the focus group to be audio recorded. I understand that once the information needed from the recordings is gathered, the recordings will be kept under lock and key for 2 two years if research is published and 6 years if not published, after which the recordings will be destroyed.

The information gathered during the course of the study is privileged information and will only be shared with the supervisors.

Signed _____

Witness _____

Date _____

Appendix 8 – Focus group questions for administrative staff

Focus Group Questions – Administrative Staff

Before the session begins the participants will be reminded that all information mentioned within the group is confidential and group rules will be set. The research assistant will run the group and can facilitate the group in English and SiSwati. The session will be audio recorded. The session will begin with a welcome and a brief introduction of all participants e.g. role in hospital, length of time they have been working at the Hospital.

This is a scenario that occurred in another hospital. I'm going to read the case study and ask you some questions about how you feel or what you would have done differently.

Case Study 1

A new health care professional arrives at the hospital to register to start working the following week. When they arrive they stop at the hospital front desk to ask for directions. The clerk is very busy and asks the health care professional to ask someone else. The second clerk is unsure where the admin department is but the third clerk is able to provide clear directions. The health care professional arrives at the HR department to sort out his final documents. The professional does not have a letter of appointment and reports that he did not receive one. He further tells HR that someone who he cannot name told him he was hired and that he should sort out the details with HR. HR phones head offices but no one answers the phone.

Questions

1. What do you think of this situation?
2. What are the biggest communication challenges between the health care professional and the admin staff in this example?
3. What could be done to improve the communication between them?
4. Can you think of a department or area in the hospital that has really good communication between health professionals? Why do you think it works in that department?
5. Communication between professionals can lead to conflict. Can you think of any examples of when you have experienced conflict and how you dealt with it?
6. What do you think you need in this hospital to help communication?
7. Do you do training or workshops with other professionals?
8. Does anyone want to share any final thoughts or feelings about communication in the hospital?

Appendix 9 – Focus group questions for allied staff

Focus Group Questions – Allied Staff

Before the session begins the participants will be reminded that all information mentioned within the group is confidential and group rules will be set. The research assistant will run the group and can facilitate the group in English and SiSwati.

The session will be audio recorded. Participants will each be given a copy of the case study. The session will begin with a welcome and a brief introduction of all participants e.g. role in hospital, length of time they have been working at the Hospital.

This is a scenario that occurred in another hospital. I'm going to read the case study and ask you some questions about how you feel or what you would have done differently.

Case Study 1

You receive a phone call from the ward to inform you that the doctor would like you to see a patient. When you arrive in the ward the nurses are unsure who the doctor would like you to see. You do a quick ward round and find two patients for therapy. The one patient is an elderly gentleman. You need more information about the patient and ask one of the nurses to help you translate. A nurse comes to the bed but informs you that she is busy and can only stay 2 minutes. You get a quick case history. After a detailed assessment of the patient you phone the doctor to report back. The doctor informs you that the patient is being discharged that afternoon. You as the therapist/health professional feel that the patient is not safe for discharge.

Questions

1. What do you think about this situation?
   What are the communication challenges between the allied staff and the nurse in this example?
2. What could be done to improve the communication between them?
3. What do you think about the communication between the allied staff and the doctor? And what can be done to improve this?
4. Can you think of a department in the hospital that has really good communication between health professionals? Why do you think it works in that department?
5. Communication between professionals can lead to conflict. Can you think of any examples of when you have experienced conflict and how you dealt with it?
6. What do you think is needed in this hospital to help communication?
7. Do you do training or workshops with other professionals?
8. Does anyone want to share any final thoughts or feelings about communication in the hospital?

Appendix 10 – Focus group questions for doctors and clinical associates

Focus Group Questions – Doctors & Clinical Associates

Before the session begins the participants will be reminded that all information mentioned within the group is confidential and group rules will be set. The research assistant will run the group and can facilitate the group in English and SiSwati. The session will be audio recorded. Participants will each be given a copy of the case study.
The session will begin with a welcome and a brief introduction of all participants e.g. role in hospital, length of time they have been working at the Hospital.

This is a scenario that occurred in another hospital. I'm going to read the case study and ask you some questions about how you feel or what you would have done differently.

Case Study 1

A baby is brought to you by one of the nurses. The nurse reports that the baby has been vomiting and had diarrhea for 2 days. The baby looks critically ill. The mother of the child does not speak any English and a nurse helps to translate. The mother and nurse converse for 5 minutes and the nurse reports a summary of what the mother has told her. The nurse informs you that the mother has been to a traditional healer but has not improved better. You request the nurse to ask if the mother has given muti and if so what? The nurse reports to you that the mother believes her baby is cursed and she gave her medicine. She then continues to talk with the patient and you are unsure what is being said. The baby's condition worsens and needs to be transferred to a referral hospital to be placed on a ventilator. You contact one of your colleagues to request help. Your colleague says he is coming to help but does not arrive. You phone them again and this time the phone is off.

Questions

1. What do you think about this situation?
   What are the biggest communication challenges between the doctor and the nurse in this example?
2. What could be done to improve the communication between them?
3. What do you think about the communication between the doctor and his colleague? And what can be done to improve this?
4. Can you think of a department in the hospital that has really good communication between health professionals? Why do you think it works in that department?
5. Communication between professionals can lead to conflict. Can you think of any examples of when you have experienced conflict and how you dealt with it?
6. What do you think you need in this hospital to help communication?
7. Do you do training or workshops with other professionals?
8. Does anyone want to share any final thoughts or feelings about communication in the hospital?

Appendix 11 – Focus group questions for nursing staff

Focus Group Questions – Nursing Staff

Before the session begins the participants will be reminded that all information mentioned within the group is confidential and group rules will be set. The research assistant will run the group and can facilitate the group in English and SiSwati. The session will be audio recorded. The session will begin with a welcome and a brief introduction of all participants e.g. role in hospital, length of time they have been working at the Hospital.

This is a scenario that occurred in another hospital. I'm going to read the case study and ask you some questions about how you feel or what you would have done differently.

Case Study 1

A psychiatric patient is in your ward. The doctors have instructed that the patient be observed carefully and that he receives medication every 3 hours. The patient is difficult to manage and has tried to hit one of your colleagues when she attempted to give him his medication. You contact the doctor and matron and ask for assistance with the patient. The patient is refusing food and has lost weight over the past few days. You contact the dietician for assistance but they report that he does not qualify as a patient to be seen by the dieticians and that psychological services should be contacted instead. Over the course of the day the patient becomes excessively violent. You contact the doctor again and ask that the patient is sedated. The doctor arrives in the ward 3 hours later and confronts you about the patients care. The doctor is upset that the patient was not given his medication and that he has not eaten his food. Furthermore the doctor expresses concern that the patient is walking around the ward unsupervised.

Questions

1. What do you think of this situation?
   What are the biggest communication challenges between the doctor and the nurse in this example?
2. What could be done to improve the communication between them?
3. What do you think about the communication between the nurse and the dietician? And what can be done to improve this?
4. Can you think of a department in the hospital that has really good communication between health professionals? Why do you think it works in that department?
5. Communication between professionals can lead to conflict. Can you think of any examples of when you have experienced conflict and how you dealt with it?
6. What do you think you need in this hospital to help communication?
7. Do you do training or workshops with other professionals?
8. Does anyone want to share any final thoughts or feelings about communication in the hospital?

Appendix 12 – Interview questions for administrative staff

Interview Questions for Administrative Staff

Hello, my name is Caitlin Longman. I'm a Speech Therapy Masters student at The University of the Witwatersrand.

I am going to ask you some questions about communication in your work environment.

The interview will take about 30 minutes.

You do not have to answer any questions that you do not wish to answer.

You may also leave the interview at any time.

I will record the interview but all information will be kept confidential. Only myself and my supervisors will listen to the tapes.

1. Tell me about the work you do in the hospital?
2. Where were you born and raised? Where do you live now?
3. What languages do you speak?
4. What would people in your community say is important when communicating with older people?
5. What would people in your community say is important when communicating with a professional like a nurse or doctor?
6. How long have you been working in your current position? And how long have you been working in this hospital?
7. Which other professionals do you work with?
8. Can you give examples of how people communicate in this hospital? Do you think people at the hospital communicate well?
9. How do you think this hospital can improve communication between professionals?
10. Do you think communication would be different if you were working in a hospital in the city? How so?
11. Do you know what National Health Insurance is?

Appendix 13 – Interview questions health care staff

Interview Questions for Health Care Staff

Hello, my name is Caitlin Longman. I'm a Speech Therapy Masters student at The University of the Witwatersrand.

I am going to ask you some questions about communication in your work environment.

The interview will take about 30 minutes.

You do not have to answer any questions that you do not wish to answer.

You may also leave the interview at any time.

I will record the interview but all information will be kept confidential. Only myself and my supervisors will listen to the tapes.

1. Tell me about the work you do in the hospital?
2. Where were you born and raised? Where do you live now?
3. What languages do you speak?
4. What would people in your community say is important when communicating with older people?
5. What would people in your community say is important when communicating with a professional like a nurse or doctor?
6. How long have you been working as a medical professional? And how long have you been working in this hospital?
7. Which other health professionals do you work with?
8. Can you give examples of how people communicate in this hospital? Do you think people at Tonga Hospital communicate well?
9. How do you think the hospital can improve communication between health professionals?
10. Do you think communication would be different if you were working in a hospital in the city? How so?
11. Do you know what National Health Insurance is?

Appendix 14 – Profile of the research assistant

Profile of the research assistant

Gender	Female			
Age	25			
Physical Address	Hazyview			
Home language	siSwati			
Language proficiency	**Languages**	**Spoken**	**Written**	**Reading**
	siSwati	good	good	good
	English	good	good	good
	isiZulu	good	good	good
	Sesotho	good	intermediate	intermediate
Highest qualification	Grade 12 (Matric certificate)			
Work experience	• Personal assistant (Orphanage) • Administrative assistant (ACTS clinic) • Administrative assistant (Toga Laboratory)			
Training	The research assistant was trained by Prof Claire Penn and Dr Jennifer Watermeyer (Health Communication Research Unit) for a research project. Her training focused on: 1. Interpreting 2. Translation 3. Transcription 4. Thematic Analysis			
Research experience	Currently she has worked as a research assistant on the following projects: • ACTS clinic • TB project • Child hearing loss			