INTERCULTURAL COMMUNICATION PRACTICES IN A HEALTH CARE CONTEXT

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DECLARATION

I, Thobile Mokoena, hereby declare that the work in this dissertation represents my own work and findings except where indicated, and that all references, to the best of my knowledge, are accurately reported.

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Thobile Mokoena

ABSTRACT

South Africa enjoys the rich cultural diversity amongst its citizens. With individuals from different parts of the world; speaking diverse languages, practising different cultural norms, holding different values and perceptions, the complexity contributes to South Africa's rich cultural spectrum. The dawn of democracy in 1994 contributed to the rapid increase in intercultural communication which placed immense challenges upon various governmental sectors, specifically the health care context (Paulston, Kiesling, and Rangel 2012:317).

South Africans have been referred to as the 'rainbow nation', a title which characterises the country's cultural diversity (Naidoo 2011: 81). Hence, this study aimed to discuss the role of intercultural communication within a health care context. It explores intercultural communication challenges that may exist within an organisation. The area of focus for this study is the private health care sector: A case study of the Entabeni Hospital in Durban, KwaZulu-Natal.

The Entabeni Hospital is a private hospital based in Durban. The hospital works with individuals from different cultural backgrounds. These individuals possess different beliefs, views and norms; this could negatively affect their perceptions and attitudes towards each other. Therefore, cultural differences can become a challenge during the communication process between the parties involved.

For the purpose of the study, a qualitative approach was employed. The study sample comprised unit managers that interact directly with health care providers and patients. Semi-structured questionnaires were used during interviews to collect data from the research participants. The main findings of this study indicated that some of the respondents were aware of importance of the role of intercultural communication within the Entabeni Hospital. The findings also highlighted the respondents' consciousness of acknowledging other cultural practises and respecting the diversity in cultural backgrounds that both patients and healthcare professionals come from, so that an effective medical process is achieved.

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CHAPTER 1: INTRODUCTION

1.1 Introduction and background of the study

Communication plays an important role in the everyday lives of all people, across the globe. It enables individuals to transmit messages between each other. Communication requires interaction from the parties involved in the communication process (Scollon, Scollon and Jones 2012: 171). Although communication is the foundation of all relationships, it can either be one-way or two-way. One-way communication allows only the message sender to release a statement, without allowing feedback from recipients of the message. This study supports two-way communication.

Griffin (2009: 6) states that communication is a sensible process for the creation and interpretation of messages that elicit a response. This implies that communication is a two-way process. The two-way process creates a platform for effective communication that results in valuable outcomes, as it allows interpretation and feedback. This is the type of communication that this study focuses on, looking at South Africa's healthcare context, with a special focus on a single hospital in Durban, KwaZulu-Natal province.

South Africa is home to approximately 50.5 million people from diverse cultural and religious backgrounds, with eleven official languages. The vast inequalities that were deep-rooted due to the previous discriminatory, racially based legislation, still exist (Rowe and Moodley 2013: 1).

South Africa is a rainbow nation where different individuals from different parts of the world come into contact. These individuals come with different world views, shaped by diverse cultural backgrounds, which may be results of diversification. Seekings (2008: 5) affirms that post-apartheid South Africa is characterised by the dual legacies of apartheid: cultural diversity and economic inequality that both have racial characteristics. These are pertinent challenges faced by South Africans and foreigners

who enter into the country. The effects of cultural diversity within the South African context appear to affect communication among the citizens of the country. Ntuli (2012: 22) points out that during the segregation of apartheid, racial groups lived in segregated areas, adding to the differences in cultural backgrounds.

Segregation can be regarded as the root cause of the growing cultural diversification in the country of South Africa. Focusing on the health care context, this study explores the effectiveness of communication among the diverse members of a healthcare care team where two-way communication and interaction is required. This study aimed to explore the role of intercultural communication, in the health context, looking at specific variables of culture.

Two-way communication during interaction between people from different cultural backgrounds necessitates the desire to understand how the challenges of the past in South Africa influence the interactions of individuals in the present post-apartheid era.

Lieres and Robins (2008: 43) state that culture has always been regarded as a significant tool of struggle and resistance and as a means of constructing new identities in South Africa. Some individuals may be resistant to change which is part of constructing new identities, usually as a consequence of fear. The fear constitutes noise that may be internal and external. The noise is usually associated with certain feelings, which are displayed when one person interacts with another. The effects of this noise will be discussed further in the next chapter. This study aims to explore how resistance to change, which can be the defensiveness of a person who is moved out of their comfort zone into a new environment (which in this context is the health care sector), affects communication.

The health care system experiences communication challenges because it deals with individuals from diverse cultural backgrounds, especially in hospitals. Since, hospitals provide intensive health care, the patients that the health care professionals render services to require more specialized care and attention. The health care provided in this context, require clear and effective communication which can be a challenge, since the medical space and the social space cultural symbols and rules differ. It is

imperative to identify the role of intercultural communication in a health care context, since health is a crucial part of a human life and in such a context two-way communication is required and expected. Mutual understanding for both the patient and health care worker is required for there to be a positive outcome from their interaction.

Coovadia *et al*. (2009: 1) affirm that the history of South Africa has had an evident effect on its citizens, health policy and health services of the present day. According to the authors (2009: 8), there is substantial inequity in health care between provinces and also within provinces in South Africa. Policies are applied to regulate and serve as sanctions for how the public and private health sector should be managed and how these sectors should operate.

Hospitals are viewed as places where people from diverse cultural backgrounds meet for health purposes, which necessitates interaction between the health care service provider and the individuals seeking health care assistance. However, both the health professionals who render the services as well as the patients may come from different cultural backgrounds.

Samovar, Porter and McDaniel (2009: 358) strongly affirm that when communication between health care professionals and patients is unclear, the entire medical treatment becomes problematic, and challenging for both parties involved. These challenges in communication could be caused by different cultural factors, including the individuals' frame of reference (beliefs, worldviews, race and class). Therefore, this study focuses on the four cultural factors which are race, beliefs, worldviews and class that may potentially affect the communication process, between health care providers and patients in Entabeni Hospital.

1.2 Problem statement, aims and objectives

Ntuli (2012: 20) mentions that much of what individuals do when they come into contact with each other is based on their cultural values and background. This reveals that culture is interrelated to communication which allows for any type of interaction, in different settings. Therefore, the culture and communication affect each other. How these two variables influence and affect one another during interactions between individuals may determine the outcome of communication.

Looking into the health care context it is evident that patients come from different cultural backgrounds, with their own beliefs and values and enter the health care setting that has its own organisational culture, rules, and principles of medicine. How all of these signs and symbols are incorporated and communicated to address the needs and objectives of the interaction between patients and health care workers, is what the study aimed to explore.

The overall aim of the study was to investigate the role of intercultural communication in a health care context: using Entabeni Hospital in Durban, KwaZulu-Natal as a case study, through the following sub-objectives:

- Investigate the existing relationship between health care professionals and patients from diverse cultural backgrounds:
- Investigate the significance of promoting intercultural awareness: and
- Identify challenges and possible consequences related to intercultural communication within a health care context.

The problem statement which developed the need for the study is described in detail in the following chapters.

1.3 Rationale

According to Samovar, Porter and McDaniel (2009: 12) when a member of one culture produces a message for consumption by a member of another culture, intercultural communication occurs.

The assumption is that patients come from a different cultural background to that of the health workers (including doctors and nurses) and enter a professional space which has its own practices different from the informal settings or societies that the patients and health professionals come from. Arising from this is the question of how these factors affect the communication between the parties involved. In addition, the researcher aimed to identify the impact different cultural symbols have on the interaction and the context in which the interaction takes place.

Furthermore, in this study the impact that social norms have on the perceptions, practices and beliefs that society members display through actions, as well as spoken and unspoken words, are considered as possible factors determining the flow of communication. Patients as individuals who receive services in a health care context, produce messages for the consumption of health workers. They both come from social contexts and so preserve informal cultural practices which then also play a role in the health care context. Ntuli (2012: 20) states that interaction is affected by cultural backgrounds from both sides, hence, this study seeks to shed light on and explore on how the interaction takes place.

This research aimed to add to the body of knowledge that already exists on the topic of culture, communication and health care, while it also aimed to assist other research students with information on the role of intercultural communication within a health care context, focusing on the private health care sector. It also aimed to obtain new information which may not have been previously observed or explored within the topic.

1.4 Scope of the study

The study focused on one hospital only, Entabeni Hospital in Durban, KwaZulu-Natal. The hospital forms part of Life Healthcare which is a group of private hospitals across South Africa. The research participants were Entabeni Hospital unit managers who interact with health care providers and patients so were able to represent both groups' views, perceptions and worldviews concentrating on race, age, gender and class.

1.5 Inclusion criteria

The study was conducted at the Entabeni Hospital in Durban, KwaZulu-Natal. The unit managers that deal directly with patients, doctors and nurses on a daily basis and who could understand and converse in English were included in the study. A unit manager is someone who oversees all aspects of operating a unit within a health care facility, from supervising nursing staff to monitoring patient care (Williams 2016).

1.6 Exclusion criteria

The study excluded all other private and public hospitals in Durban and participants who were not willing to participate in the study. There was no direct contact with the patients of Entabeni Hospital. Communities and animals outside and within Durban were excluded in this study. There was no government organisation that was contacted and requested to be part of this study. No public sectors were not involved in this study. The inclusion and exclusion criteria for this study considered relevant ethical issues including confidentiality and anonymity of all participants.

1.7 Ethical considerations/ confidentiality and anonymity

This study did not cause harm to humans, animals and the environment. It did not pose a threat to the rights and cultural values of the participants. Participation in the study was based on individual willingness to participate in the study. Letters of informed consent and information regarding the study were made available at all interviews accompanied by questionnaires. Participants were assured of anonymity; confidentiality and all information of the study has been kept in confidence.

1.8 Research methodology

Research methodology seeks to address the steps to be taken to conduct the research, gather data from participants, and respond to the objectives of the study. Leedy and Omrod (2010: 93) state that data is like ore in a sense that data contain pieces of truth that are not refined and that to extract meaning from the data, research

methodology should be employed. Therefore, a research method is employed to gain explanations from raw data. Research scholars explain two types of methodologies that can be used for a research study: qualitative and quantitative.

For this study a qualitative approach was employed. Qualitative research refers to non-experimental research that asks questions pertaining to people making meaning out of the world (White and McBurney, 2013:192). Instead of sampling a large number of people with the intent of making generalisations, Leedy and Ormrod (2010: 96) explain that qualitative research is exploratory in nature and qualitative researchers tend to select a few participants who can best shed light on the phenomenon under investigation. It for this reason that the researcher opted for a qualitative approach, to obtain data from staff of the Entabeni Hospital about their intercultural communication experiences.

The target population for this study was health care professionals of Entabeni Hospital who were perceived to be able to provide valuable information and add knowledge to the subject under consideration. Participants were selected based on the fact that they worked closed with patients and hospital staff. Participants needed to able to understand and converse in English as this was the main language of communication throughout the study.

Participants were selected on the basis of nonprobability sampling which is appropriate when the researcher has no assurance that each element in the population will be represented (Leedy and Omrod 2009: 211). There was no certainty that every patient with these cultural variables: race, gender, age and class would be represented, as patients had been excluded to avoid inconvenience on their part, and they could only be represented by the Entabeni staff.

Since this was a qualitative study, a semi-structured questionnaire was administered by means of personal interviews. Alvesson and Sandberg (2013: 11) affirm that questions provide the basic path for all forms of knowledge development. The questions aimed to provide answers to the objectives of the study, namely, the role of intercultural communication that occurs between health care professionals and

patients from diverse backgrounds, as well as their attitudes, perceptions, feelings and beliefs.

The nature of this study required that primary data gathered from the interviews be analysed and used to offer recommendations for the study. The data was organised into themes and analysed using Microsoft Excel and then translated to tables and graphs using SPSS. Salkind (2010: 2) describes SPSS as “a computer-based data management and inferential statistical analysis program”.

It is imperative to note that the data provided needed to be tested for validity and reliability. Therefore, to ensure validity and reliability of the data submitted, a questionnaire that interlinks to the objectives of the study was used as a measuring tool. To ensure reliability, each of the sections in the semi-structured questionnaire was explained by the interviewer to alleviate misunderstandings. The next section provides an overview of the chapters of this study.

1.9 Overview of the chapters

Chapter 1: Introduction

This chapter provides a significant background of the study and an overview of the problem statement of the study, while introducing the objectives of the study. It also presents the rational and scope of the study.

Chapter 2: Literature review

This chapter critically focuses on literature of intercultural communication in relation to health care context that is the theoretical framework of the study. It also presents an in-depth discussion on culture, communication, healthcare setting/sector and how these interrelate, based on reviewed literature by scholars in the fields of culture, communication, and intercultural communication, as well as researchers who have published research papers and theses.

Chapter 3: Research design and methodology

This chapter outlines the research methodology of the study based on the literature review. The research process as well as the research tools used to gather and analyse data are discussed in depth.

Chapter 4: Findings and analysis

In this chapter, findings based on the responses from the questionnaires and the interviews are analysed and presented.

Chapter 5: Conclusions and recommendations

This chapter offers conclusions and recommendations based on the findings and analysis. It also compares the findings to the data provided in Chapter 2 with the findings analysed in Chapter 4.

1.10 Conclusion

This chapter provides highlights from the whole study. providing a summary of the study and the objectives. The next chapters will provide detail description of the theories, and methods that govern the study.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The previous chapter introduced the purpose of the study and summarised the components the study. This chapter aims to review and analyse the literature that underpins intercultural communication within the health care context. It aims to explore the role of intercultural communication within a health care context through a theoretical framework that discusses communication, culture, the relationship between culture and communication, intercultural communication, intercultural competence, uncertainty reduction theory and identity-negotiation theory. The chapter will show how the theoretical framework relates to and influence communication in a health care context. This chapter therefore analyses and investigates the theoretical framework that underpins intercultural communication.

2.2 Communication

The role of intercultural communication cannot be analysed unless communication is described, and the role of communication is identified. This study aimed to identify the effects of culture during a communication process, which requires that the descriptions of communication be identified, since communication is the foundation of all human interactions.

2.2.1 Descriptions of communication

According to Pearson *et al*. (2013: 9), communication is considered a process since it is an activity, an exchange, a set of behaviours and a variable product. As culture continues to evolve so does communication. The processes may change and vary according to the context, subject and participants. Since culture and communication involve people whose cultural variables (language, gender, age, race, and other cultural symbols and rules) differ, this may have an impact on how the individuals communicate with each other. The variables may contribute and influence how

individuals relate to each other which is a response to the environment which they live in. Cultural variables can determine how individuals define situations and how they make sense of events that may occur during their exposure to the surroundings. Therefore, communication as a process allows communicators to interpret messages according to the cultural symbols which they are familiar with.

Griffin (2009: 6) suggests that the process of communication requires an interaction where messages are created, shared, translated and feedback is received. This suggests that the participants involved in a communication process need to be active in how they converse: interpret the messages created. Furthermore, communication is a process, not a freeze-frame snapshot (Griffin 2009: 6). This emphasises that communication goes through certain stages and cannot be treated as just a one-way process where one communicator is passive, and the other is active.

Both participants need to be active. Interaction and active participation of a sender and a receiver is vital in order to translate the created message, and thereafter provide feedback. Littlejohn and Foss (2008: 3) affirm that communication is the transmission of information which is not necessarily received or understood. This highlights the importance of both the sender and the receiver being active to ensure that the message created is accurately transmitted, received, and understood which then prompts feedback.

Feedback is necessary for the agenda to be complete. The success and effectiveness of communication of the message transmitted can be measured by the feedback received. This study intends to identify: (1) if the participants involved in a communication process within the health care context are active participants that engage in feedback and (2) how do the participants conduct themselves during the communication process. Having reviewed Pearson *et al.* (2013) and Griffin's (2009) view of communication it becomes evident that communication is more effective when it is two-way. This is the core emphasis of this study. Effective communication requires both the sender and the receiver to be completely involved.

In a health care context, health care research scholars affirm that clear communication is vital to avoid any unfortunate occurrences, which could be fatal. Therefore, it is imperative that the parties involved in the process become aware of the roles they play during interactions which are initiated by communication. Using Entabeni Hospital as a case study, this study aimed to explore the effectiveness of two-way communication between diverse cultures. Communication should be a positive practice, that ultimately benefits an organisation. The fundamental purpose of human communication is to create action on the part of the receiver, but each human has a unique model of himself or herself and the world (Scheming 2012: 21). In order for health care professionals as well as patients to understand the communication model, they need to be knowledgeable of the different communication models (two-way communication models).

The models in Figure 2.1 and Figure 2.2 provide useful information as to how the process of effective communication works. Both patients and health care providers need to understand that a message is the pre-requisite of communication and the message must be conveyed through some medium to the recipient (Management Study Guide 2017a). Figure 2.11 shows a model of the communication process.

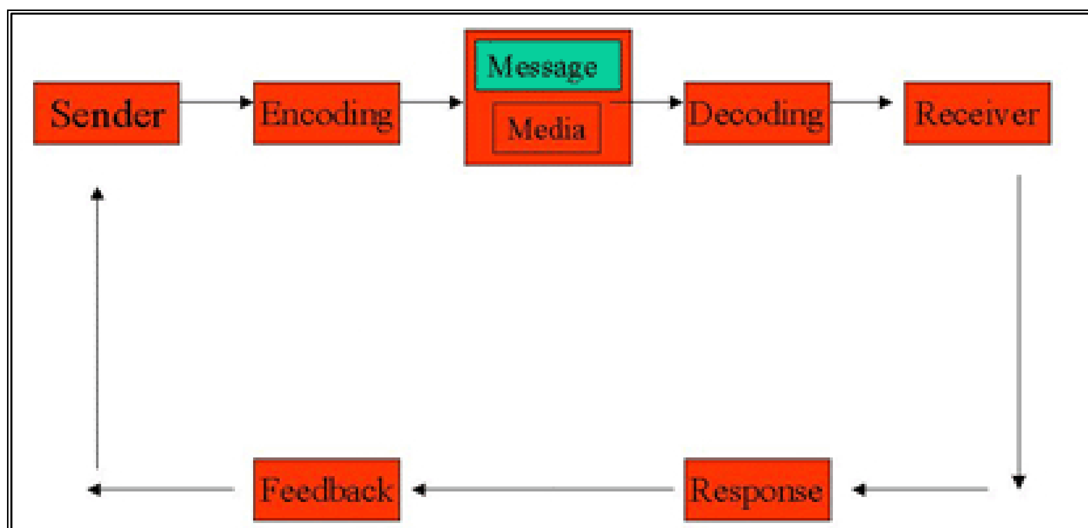

Figure 2.1: Communication process model
Source: Management Study Guide (2017:1)

In Figure 2.1 the message is highlighted in green, which gives the impression that a message is what gives the process a "green light", i.e. permission to proceed. This denotes that without the message, communication is incomplete and stagnant.

Moreover, Figure 2.1 indicates that the purpose for communication is encoding and decoding of the message. Figure 2.2 shows a model by Shannon and Weaver which provides a thorough description of the communication process.

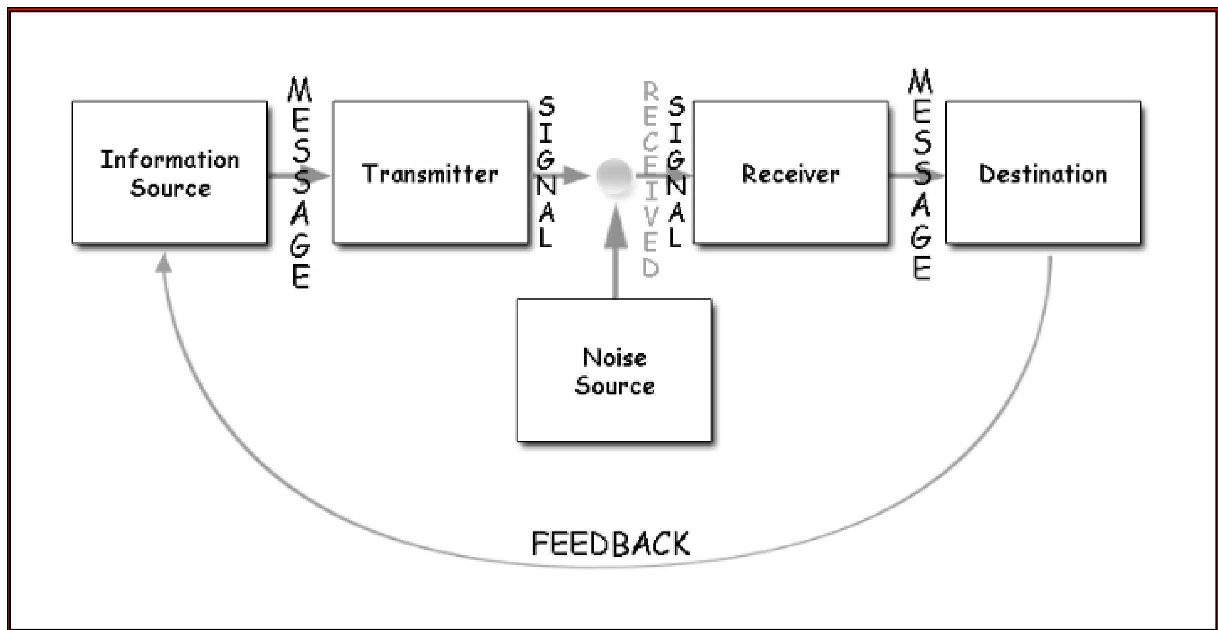

Figure 2.2: Shannon and Weaver model of communication (2017: 1)
Source: Mishra (2017: 1)

Referred to as the “mother of all models”, Shannon and Weaver’s model is one of the prominent communication models in the field. This model of communication supports this study’s topic, which is about effective interactive communication. Figure 2.2 shows how information, which is enclosed in a message form, is transferred through signals in an attempt to reach the intended party. The Shannon and Weaver model infers that there are always noises (internal and external noise) that influence how the message is received. Feedback on the message received is influenced by the noise and the channel (signal) utilised. Thus, interaction is crucial, and cannot be ignored.

Transmitting the message through appropriate channels is vital, while the sender should be aware of the potential hindrances (noises). Examples of how the noise affects how the receiver projects the feedback to the sender will be discussed later in the chapter. The model in Figure 2.3 simplifies interactive communication, where feedback is the measurement tool and is attached to experiences.

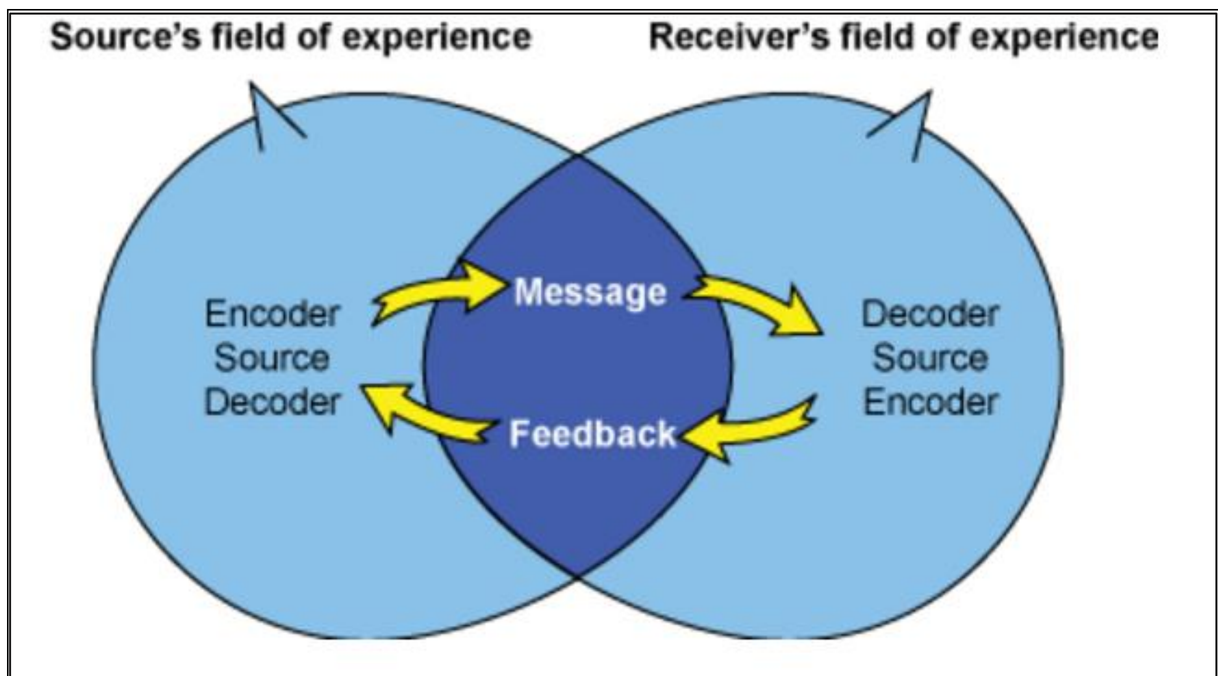

Figure 2.3: Interactive model of communication
Source: Mishra (2017: 1)

In Figure 2.3 the source refers to the message sender who disseminates information through a channel to the receiver who is expected to interpret the message and respond to it. The response from the receiver becomes the feedback. Figure 2.3 affirms what has been mentioned in the previous paragraphs that feedback is crucial in that both the sender and receiver can decide what part of the message needs to be changed and what part needs to be clarified. This is imperative in order to disseminate the intended message. It is important to note the influence of the noise as it affects the type of feedback given by a receiver to the sender. The output of the message depends on the level of consideration of all these factors by the key participants, namely, the receiver and sender.

Interactive communication models represent a process in which the receiver gives feedback and, therefore, responds to the message from the sender (Wood, 2009: 17). Figure 2.1 represents one interactive model. Pearson *et al.* (2013: 10-11) summarised the ten components of communication into four components of communication: 1) people: the source and receiver, 2) the message: verbal or nonverbal idea, thought or feeling, 3) the channel: means by which the message moves and 4) feedback: the receiver's verbal and nonverbal response to the source's message. The ten

components identified by Jandt (2013 42) comprises a noise element which is either internal or external factors, thoughts, and verbal and nonverbal responses that influence how a message reaches a receiver who is then expected to provide feedback.

The channel used to transmit information somehow influences the feedback sent to the sender by a receiver. Therefore, it is imperative that a sender chooses an appropriate channel, considering the noises that may affect the accuracy of the message. Focusing on the health care context, the question which arises is the following: how do the internal and external noises influence the messages transmitted, received and translated between healthcare providers and patients?

Jandt (2013: 42) stipulates that the noises comprise thoughts, beliefs, views and opinions of an individual. These are both internal and external noises. The noise influences how individuals respond to and translate messages. Meanwhile people occupy spaces which are referred to as environments where individual's live, which influences how the individual transmits and responds to information. The environments that individuals reside in are occupied by other humans who have their own beliefs, perceptions and worldviews that are acquired during interactions with others. Thus, individuals interact and respond to situations among themselves and as well as to the environment.

Sorrells (2013: 55) affirms that the ongoing communication and social interactions help people to acquire knowledge about themselves, the world, and everyday reality. Therefore, communication is understood to be vital as it allows people to interact, enabling them to communicate, despite cultural differences. Meanwhile they will be experimenting and learning about the other, which is what intercultural communication is, and will be discussed later in this chapter. Learning about other cultures is part of intercultural communication and provides a platform for better understanding of the cultural variables, improving the clarity of transmitted messages so resulting in effective communication.

The key to effective communication is understanding (Naidoo 2013: 14). In order to understand what communication is about and also provide clarity of what defines effective communication, characteristics of communication need to be identified and defined. The understanding of the attributes of communication will enhance the communication process among the communicators. Communication is directly proportional to the choice of words or its content. The more precise and crisp the content is the more effective the communication would be (Management Study Guide 2017: 1).

Naidoo (2013: 58) confirms that effective communication draws out the ability to listen and accept feedback which is a two-way process and necessary for intercultural settings. Scholars of communication and health care research have emphasised the importance of clear communication in a health care context. unclear communication: where messages are misunderstood, can be fatal.

Pearson *et al.* (2013 15) add:

> Communication largely involves characteristics of all parties involved in the process: sender, the receiver, and the setting where the interaction takes place. Furthermore, the selection of the message, which could be nonverbal, verbal, the aspects, and the choices surrounding the transmission channel used and behavioural, are crucial in the effectiveness of the communication process.

People who wish to partake in a communication process need to be familiar with the characteristics of communication. Sorrells (2013: 10) states that communication is a process approached in order to apply cultural properties. Thus, culture and communication cannot be separated, as communication is the appropriate and only tool used to translate cultural variables, either verbally or nonverbally. Cultural signs, rules and symbols can only be interpreted and understood through the process of communication. Therefore, in a health care setting communication is vital to disseminate information between health care workers and patients, with the parties expected to analyse and respond to the information provided. The tool of good

communication is necessary in order to be able to make sense of and explain events that occur within the health context. communication is the tool to be used.

2.2.2 Characteristics of communication

Pearson *et al*. (2013: 13-16) mention the following principles of communication which can also be described as characteristics of the communication process:

Firstly, communication begins with the self, meaning that communication is limited by an individual's own view of every situation. This suggests that noises (thoughts, feelings) are established internally within an individual. It all begins with how individuals personally define situations and how those thoughts affect the manner in which they communicate with others, since communication also involves others. Secondly, it involves others in the sense that a competent communicator (a person who is sensitive to and acknowledges differences in communication) considers the other person's needs and expectations when selecting messages to share. These are the two most important characteristics of communication.

Thirdly, communication has both a content and relational dimension. The message provides substance and suggests a relationship among communicators. The fourth characteristic of communication is that communication is complicated, which means that it is far more than simple information transmission. The fifth characteristic of the communication process is that it cannot be avoided nor reversed. Therefore, it is important that the participants in the communication process are aware of all the factors involved in communication so that they can avoid any misunderstanding that may be prompted by external noises (social norms, values, and worldviews). Because communication cannot be repeated, people involved in the process need to be sensitive to the messages transmitted between them.

The principles described by Pearson *et al* (2013: 13-16) confirm Griffin's (2009: 6) definition of communication, which is that communication is a process. The complexity of communication is that it may demand of people wishing to participate in the process to thoroughly learn the principles of communication, so as to avoid any possible

barriers that may have negative effects on the intended message. After the sender and receiver have studied the principles they will understand the role of communication and be able to choose the appropriate channels for transmitting messages. Communication is a combination of transmitting information and listening, Speak (2014: 1). The next paragraph provides a thorough answer to the question: what is the role of communication?

2.2.3 The role of communication

If one could thoroughly think about it, what are the possible ways that we use to transmit messages to each other as living beings? How can we share our experiences? These are the kind of questions that require a clear comprehension of the role that communication plays every moment of our existence. Communication is a process in which there is an exchange and progression of ideas (Scheming 2012: 23). It plays a major role as it brings people together and allows them to share their feelings, thoughts and ideas.

According to Liu *et al*. (2011: 190), communication is the key to developing intercultural relationships. It is impossible to make sense of how people send and receive messages without communication. Messages sent through verbal and nonverbal signs, symbols and words can only be understood through communication. Communication serves as the basis of all human relationships, Speak (2014: 1).

The focus in this study is on the idea that individuals can use symbols and signs to form their own culture that will sustain their relationship. However, differences in ideology can negatively affect their communication. Such negative effects are referred to as barriers to communication.

2.2.4 Communication barriers

Communication barriers are factors that have a negative effect on communication and so hinder the success of the process of communication.

Chaney and Martin (2011: 13) list the following nine communication barriers:

1. Physical – time, environment, comfort, needs and physical medium.
2. Cultural – ethnic, religious, and social differences.
3. Perceptual – viewing what is said from your own mind set.
4. Motivational – the listener's mental inertia.
5. Experiential – lack of similar life happenings.
6. Emotional – personal feelings of the listener.
7. Linguistic – different language spoken by the speaker and listener or use of vocabulary beyond the comprehension of the listener.
8. Nonverbal – no word messages.
9. Competition – the listener's ability to do other things rather than hear the competition.

The barriers of communication are in sync with cultural barriers. They indicate the relationship between culture and communication. Listen and hearing are two different acts. It may sound like a cliché, but most of us are aware that listening is a skill, and it requires one to be aware of general communication barriers to avoid the conflict of misunderstanding. This is important because the awareness of previously listed barriers enables a communicator to pay attention to differences between ourselves and the other and to what the other person brings to the communication process so that we can understand them.

The barriers listed by Chaney and Martin (2011: 13) are relevant to this study, since the health care context is a physical space that is culturally and perceptually influenced while it is also an emotional experience, that can be verbally or nonverbally communicated. The communication competitiveness of an individual to communicate, determines the success and failure of the communication process. These differences in these that causes conflicts of understanding during communication between individuals who are from different backgrounds, which thereafter result in barriers in communication. The different backgrounds involve the experience, language, and emotions and other aspects that are listed by Chaney and Martin (2011: 13), these form part of and are influenced by culture, which then affects communication.

2.2.5 The role of communication barriers in ineffective communication

According to the Difference communication and Effective Communication (2017: 1) The following are the barriers to an effective communication:

Noise – Noise plays an important barrier to effective communication. Any presentation or speech delivered in a noisy classroom or auditorium is pointless as the information would never reach the ears of the listeners. For example, sharing some information in an overcrowded bus with a friend may mean that accurate information might never reach the recipient and they may be unable to interpret and respond to it accordingly. Therefore, noise results in the distortion of the message and is regarded as an external communication barrier.

Unorganised thought – Thoughts that are random and chaotic are instrumental in poor communication. For example, the following conversation between two people, shows how confusion arises and can result in inaccurate interpretations, which may lead to ineffective communication: Smilo to Hlelo - "Can I visit today, maybe not today, am coming today, fine let us meet up today". Hlelo is bound to get confused as Smilo himself is not clear about the visit. The sender must pass on crystal clear information to the receiver. Haphazard thoughts and abstract ideas can lead to ineffective communication. Therefore, before the sender conveys the message, he/she may need to first be very clear what he/she wants to communicate.

Wrong interpretations – Wrong interpretations play a very important role in miscommunication. Information can be wrongly interpreted by the receiver leading to a complete mess. For example, "Tiff went for a run yesterday". The word run can be decoded as jog. The sender might convey his/her message to the recipient in order to provide some necessary information, but the receiver might misinterpret it. It is the responsibility of the receiver to give proper feedback to the speaker and clear all the hesitation before ending the conversation.

The previous paragraphs have defined what communication is, its importance, and the variables that affect effective communication. This study supports effective

communication across cultures, in a health care context. Thus, it is imperative that we draw an understanding on how communication relates to culture.

2.2.6 The relationship between communication and culture

The previous literature indicated that there is a strong relation between culture and communication. Scholars of communication and culture have indicated that the variables of culture and communication are interdependent on each other.

Sorrells (2013: 10) explains the two following definitions of culture which illustrate different assumptions about communications:

Athropological – culture is a shared system of meaning, while communication is a process of transmitting and sharing information among a group of people; in this case, communication enables culture to be co-constructed and mutually shared by members of a group. Cultural studies hold the view that culture is a disputed site of meaning, and that communication is a process through which individuals and groups negotiate and struggle over the agreed upon and appropriate meanings assigned to reality.

Globalisation – culture is viewed as a resource while communication is a productive process that enables change. This means that culture is a snapshot that can be explained through communication. It suggests that culture cannot be apprehended if there's no communication to clarify it and provide its significance. Dreachslin, Gilbert and Malone (2012: 239) support the view that culture and communication style is inseparable because one's culture is transmitted and preserved through communication.

Based on these definitions, one is able to understand the relationship between culture and communication. Dreachslin, *et al.* (2012: 239) add that culture determines a communication style while it influence its preference through how it affects and determines a communication style which thereafter mould culture. Depending on the cultural background an individual comes from, the experiences and emotions attached to certain cultural symbols are likely to influence the manner in which they

communicate – the language usage, tone and the ability to comprehend what is said. Dreachslin, *et.al.* (2012: 239) observe that communication can shape its own culture: the communication style used, in itself, can determine a new culture.

A hospital is a corporate setting with its own corporate culture but needs to deal with patients who come from a variety of cultural backgrounds. Sorrells (2013: 10) explains that culture is a resource which communication utilises through its processes. In the communication process, a sender that a message which will be informed by cultural content such as emotions or experiences, then sends it through a channel that is chosen with the receiver in mind. The receiver may provide feedback, depending on how he/she translated it, which also is informed by cultural content such as emotions and experiences.

In a health care setting, health care workers need to ensure that accurate communication channels are used to disseminate information to patients, particularly where feedback is required.

Liu et al (2011: 48) affirm that communication and culture cannot be separated. It makes no sense that something that gives meaning to the symbols that are developed to transmit certain information is separated from it. This is the primary reason why culture is dependent on communication. The reality is that without communication, it is impossible to figure out situations, explain them, interpret them and understand them. Hence, communication is an ongoing process.

Samovar, Porter and McDaniel (2010: 36) affirm that communication is a continuous process through which cultural habits, principles, values, and attitudes are formulated, and they are communicated to each member of the culture. This enables members from diverse cultural backgrounds to create common cultural practices which can be communicated among themselves. In a health care setting, communication enables patients and health care workers to form new customs and rules that are culturally bound, on daily basis.

Chaney and Martin (2011: 5) state that whereas communication is a process, culture is the structure through which the communication is formulated and interpreted. This allows for interaction, as messages can be shared, and responses can be obtained. Culture provides a platform for message creation and for the messages to be understood, which then suggests interaction. The fact is that without culture there is no communication, and without communication, culture cannot be understood and interpreted by individuals involved in the communication process. At the same time, communication is an ongoing process which implies the possibility of change, so as times change, culture evolves as well.

Paulston, Kiesling, and Rangel (2012: 67) affirm that to interact is to engage in an ongoing process of negotiation, both to infer what others intend to convey and to monitor how one's own contributions are received. Without communication this is impossible. Paulston, Kiesling, and Rangel (2012: 68) aver that where background knowledge is not shared, interpretations may differ, and this is precisely what tends to go wrong when two people from diverse cultural background interact. Background information can only be shared through communication. Communication participants need to be aware that background information composed of various cultural variables cannot be ignored and needs to be shared in order to help the other person understand where one comes from, which can explain one's preferences and behaviour. This also needs to be born in mind when trying to understand someone else.

Jandt (2013 37) maintains that culture cannot be known without a study of communication, and communication can only be known with an understanding of the culture it supports. For instance, when an individual does not know the culture another person comes from, it may be difficult to understand the type of communication style to use when communicating with that individual. Communication helps one understand which cultural rules and symbols to use and how to communicate, in order for the other participant in the communication process to be able to accurately understand and interpret the message sent and received. This simply means that it is impossible to explain and be able to comprehend cultural symbols without communication which provides meaning to the symbols.

A symbol may exist, but it will be useless if it is not explained and no meaning is attached to it. Communication provides a platform for cultural signs and symbols to be used effectively, because once meaning is attached to them, an action through communication can take place. Effective response happens best in a corporate culture that supports and encourages openness and communication (Scheming 2012: 46).

The literature has indicated how impossible it is to separate culture and communication. Therefore, is imperative to discuss the role played by the two variables of culture and communication in conjunction with one another. The next subheading discusses culture in detail: what it entails and its variables. Combining culture and communication leads to intercultural communication.

2.3 Culture

Chaney and Martin (2011: 5) affirm other scholars' definition of culture that it is a channel through which communication is expressed and understood, while communication is a process used to achieve this. Sorrells (2013:4) states that culture is a vital component of communication which allows us to make sense of, express, and give meaning to our lives. The relation between the two will be discussed in depth in the next topics of the literature review.

Culture serves as a guideline to behavior, it entails a of set rules, beliefs and values that govern certain practices while it determines to a large extent the activities people engage in (Ijabendeyi 2014: 32). In a health care context, culture serves to provide direction for both health care workers and patients' behavior and other practices which then govern how activities are conducted within the context.

Pearson *et al*. (2013: 142) concur that culture is a unique combination of rituals, religious beliefs, ways of thinking, and ways of behaving that unify a group of people. Thus, to effectively communicate with an individual from a different cultural background to one's own, it is helpful to be able to identify the cultural background of that individual (Pearson *et al*. 2013: 142). Hofstede, Hofstede and Minkov (2010: 23) observe that people's own culture is to them the air they breathe, while another's

different from their own can be compared to being under water, and to survive in the two different environments takes special skills.

Andreatta and Ferraro (2013: 34) state that everything that people have, think, and do as members of a society becomes their culture as a society. Hence, environment plays a crucial role in shaping individuals' thoughts and behaviours. Thoughts are shaped in a particular society then influence and affect how an individual thereafter communicates with others, within the society and externally. From the definitions, it is evident that culture relates to people and how they make meanings of an environment. Therefore, it can be stipulated that without culture what people do cannot be explained, as no meaning will be attached to that specific practice and behaviour.

From the above definitions of culture, it is evident that culture, people and environment cannot be separated. People form meanings through culture, which becomes a way of life for them, so they require special skills to survive in different settings. Figure 2.4 shows the components of culture.

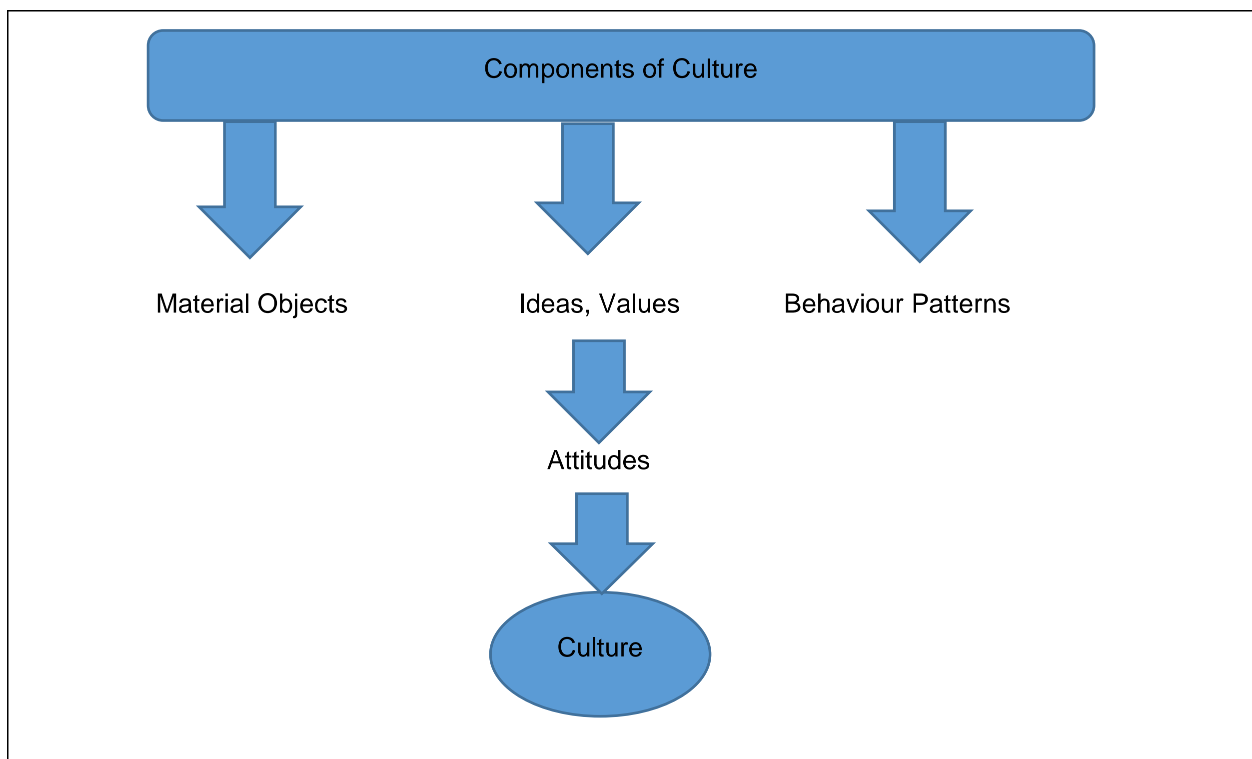

Figure 2.4: The components of culture
Source: Andreatta and Ferraro (2013: 34)

Figure 2.4 indicates that culture is composed of three major components. The diagram also indicates that material objects influence an individual's thoughts and values which thereafter affects their behaviour. The material objects and be cars, houses, money and so forth which then leads to a certain attitude that becomes a culture for that individual.

Asante *et al*. (2013: 52) mention that culture was the single most important global communication issue in the 1990s and is still a prominent challenge in the 21st century. Culture is still a challenge today because it is ever changing and influenced by new practices of modern-day society. Therefore, research on the topic of culture is still relevant in order to identify the challenges and develop solutions.

The previous definitions of culture evoke an understanding that culture is shared and is common among a group of individuals. A group of people teach one another the principles and rules which then create their culture. The individuals the group do not just interact; they are interdependent (Adler and Rodman 2009: 231). This understanding suggest that a person is not born with a culture but learns it as they grow. Thus, culture is socially constructed and historically transmitted through the pattern of symbols, meanings, premises, and rules (Phillipsen cited in Griffin 2009: 384).

2.3.1 Characteristics of culture

Samovar, Porter and McDaniel (2007: 21-30) identify the following six characteristics of culture:

1. Culture can be learned.
2. Culture is shared.
3. Culture is transferred from generation to generation.
4. Culture is based on symbols.
5. Culture is dynamic – this means it is subject to change.
6. Culture is an integrated system.

The characteristics of culture can be comprehended through communication, which suggest that culture and communication are related and interdependent. It makes sense that an individual learns culture, because no one is born knowing which rules, norms and beliefs they should live by. A person can only be taught a culture in different ways and different settings. Thereafter, the lessons learnt can be shared through those same contexts, while the communicators are sensitive to the existing information, to be able to give meaning that is relatable to the existing one. Thus, in order to share cultural experiences, communication is key in sharing of information, experience and it is learned throughout the process.

Samovar, Porter and McDaniel (2010: 27) affirm that culture is learned by giving meaning to the experiences that are learned and are culturally based. While Andreatta and Ferraro (2013: 36) define how culture is shared and explain that any component can only be translated through communication to qualify as being cultural, Samovar, Porter and McDaniel (2010) and Andreatta and Ferraro (2013: 36) emphasise that culture is learned through the sharing of components that emanate from different backgrounds.

Samovar, Porter and McDaniel (2010: 36) state that if a culture is to sustain its crucial messages these must be passed on to future generations. The authors suggest that ancient practices have a potential to influence current behaviours, since they can be passed from generation to generation. Therefore, it is helpful for each participant involved in a communication process to learn about another person's background. Andretta and Ferraro (2013: 47) confirm that cultural change is brought about by internal and external factors: internal factors are inventions and innovations, while external factors are cultural diffusion (spreading) between cultures.

Andreatta and Ferraro (2013: 46) state that cultural integration means that most cultural symbols are not only connected to one another, but they influence one another. It is important to note that culture is adaptive because it enables people to adapt to new environments that obligate different cultural practices from their own, thus increasing their chances of survival (Andreatta and Ferraro 2013: 50). It is human nature to try and develop a means of survival, especially when exposed to a new

experience. Sorrells (2013: 190) affirms that “culture today is a product that is invented, packaged, and consumed.” Generally, it is humans and other living beings that consume, create and take action. How people form a culture is the most important phase – the formation of culture.

2.3.2 The development of cultures

Holliday (2013: 3) sustains that primary culture formation is the major area where the underlying universal cultural processes come into operation. Banwell, Ulijasjek and Dixon (2013: 3) state that anthropological and sociology studies agree that culture is a guide that is not ordering what is imaginable, moral, and possible, but teaches. This definition of culture creates an understanding that people are not obliged to follow any principles of culture but can use it as guidelines that can assist them to have a sense of direction.

According to Banwell, Ulijasjek and Dixon (2013: 3) the following are spheres where culture is found and is created:

- Global: at this level, there are adherents to the global rule of law, trade rules, financial system rules, and environmental treaties along with ideas shared through migration, technology, and the media.
- National: governments enact societal level laws and policies that are intended to encourage particular behaviour and not others.
- Community/social: here, cultural systems may encourage and rule out decisions about how, when, where, and what health related actions to take and equally what happens at this level can also change the cultural system. Individuals are encompassed for the reason that there is growing interest in the idea of human adaptability to environmental conditions. It is also imperative to understand the theory of culture and the methods of the human origin, as it is humans that form, learn and practice culture, in all the spheres.

2.3.3 The theory and methods of culture

Anthropology is the study culture and its origins and explains the depths of culture and how it evolves. The people who study it are knows as anthropologists.

Andreatta and Ferraro (2013: 3) explain athrolopology as being the study of humans, their origins, development and their contemporary variations, wherever and whenever they have been found. Furthermore, Andreatta and Ferraro (2013: 4) state that anthropologists attempt to gain an understanding of biological and cultural origins that contribute to the evolutionary development of the species. Traditionally the discipline of anthropology is divided into four distinct branches which are displayed in Table 1.

Table 2.1: Types of anthropologies

Physical Anthropology	Archaeology	Anthropological linguistics	Cultural Anthropology
Scientific study of human from a biological perspective	Studies the lifeways of people from the past by excavating and analysing the material culture they have left behind	Studies human speech and language	Deals with the study of specific contemporary cultures
Looks at the biological and behavioural characteristics of humans and non-human primates	Purpose is to understand the cultural adaptations of ancient people by partially reconstructing their cultures	Analyses the structure and patterning of language and the origins of language	Comprises two facets: ethnography and ethnology
Investigates the reconstruction of the anatomical and behavioural evolutionary record of human species from fossil remains	Work with three types of material: artefacts, features and eco facts.	Divided into four distinct branches: historical, descriptive, ethnolinguistic and sociolinguistic	Cultural anthropologists deal with enormous cultural diversity, numerous features of culture that can be compared, and a wide range of theoretical frameworks for comparing them
Primatology – the study of evolutionary fossil records of our nearest living relatives and the behaviour of living populations in their natural habitats	Limited to material remains and fragments of material evidence such as beads and postholes.	Historical linguistics – deals with the emergence of language in general and how specific languages have diverged over time	More time is required to describe complex cultures
Investigates human variation – deals with how and why physical traits (skin colour, body proportions…) of contemporary human populations vary throughout the world	Present archaeologists work with both historic and prehistoric cultures and specialise in cultural resource management	Descriptive linguistics studies the sound systems, grammatical systems, and the meanings attached to words in specific languages. Ethnolinguistics – examines the relationship between language and culture. Socio-linguistics – examines the relationship between language and social relationships	Ethnographers rarely describe total cultures; instead they describe only the more outstanding features of a culture and investigate a particular problem in greater depth

Source: Andreatta and Ferraro (2013: 5-12)

The above table explains the four types of anthropology from the physics' definition to culture. Chaney and Martin (2011: 13) list linguistics as being one of the barriers to

communication. According to the authors, linguistics is defined as “different languages spoken by the speaker and listener or use of vocabulary beyond the comprehension of the listener”. This is the reason why it becomes vital that communication, anthropology is defined and comprehended by individuals who wish to engage in intercultural communication, where language can be a potential barrier.

Artefacts are objects that have been made by humans and can be removed from archaeological sites and taken to the laboratory, whereas features are made by people but cannot be readily carried away from the dig site and eco facts are objects found in the natural environment (Andreatta and Ferraro 2013: 9).

Table 2.2: Two facets of cultural anthropology

Ethnography	Ethnology
Descriptive	Comparative
Based on direct field work	Based on data collected by other ethnographers
Focuses on single culture or subculture	Generalises across cultures or subcultures

Source: Andreatta and Ferraro (2013)

Chaney and Martin (2011: 13) state that what an individual does not perceive as cultural, can become a barrier and prevent the individual from being an effective communicator. This can prevent people involved in a communication process from completing their agenda. Banwell, Ulijaszek and Dixon (2013: 19) are of the view that all contemporary anthropologists and their colleagues in neighbouring disciplines stress variations in cultural meanings to be both important and observable, and they constitute the difference that brings variation to all dimensions of human life.

Banwell, Ulijasjek and Dixon (2013: 19) state that “the effect of the critique of the older notion of culture has led anthropologists to focus on the analysis of specific cultural settings and their historical trajectories, including differences within social formations.” Culture is formed within social interactions, which can be either formal or informal, depending on the nature of the setting. For instance, in a health care context as it is in a corporate environment, the type of culture practised and implemented is formal.

2.3.4 Informal and formal culture

According to Samovar, Porter and McDaniel (2010: 288), cultures can have informal to very formal opinions regarding events and people. How people create and attach meaning to a cultural symbol makes it either formal or informal. A setting in which meaning is shared also defines the type of culture that meaning provides.

Samovar, Porter and McDaniel (2010: 288) mention that culture can be informal as represented by certain gestures among people of the same culture who all understand them but may result in misunderstanding by people from other cultures. Therefore, it is imperative to understand the formal and informal opinions of different cultures. A group of people that develops certain cultural practices which comprise certain opinions need to learn about different cultures and be able to comprehend them before they are practised. This can avoid potential communication barriers which are most likely to be the result of stereotyping. In a health care context, as any other field, has its own jargon which can be regarded as formal, and can be understood by health care providers but not the patients. Therefore, it is crucial to know if patients are aware of the language and rules difference.

Samovar, Porter and McDaniel (2010: 289) explain that the formality of cultures require the people of that culture to strictly follow the cultural rules, and not knowing the rules can cause problems and complications which may hinder the communication process. Misunderstanding can be caused by the inability of both parties to use symbols of communication which they both can understand. These people need to teach each other the symbols, which require a learning phase.

Samovar, Porter and McDaniel (2009: 21) point out that culture is learned informally through proverbs, social practices and formally in places such as schools, churches and professional settings (e.g. a hospital). Since it is possible for individuals to unconsciously acquire culture through interaction in various settings, it is important that the key individuals in such settings be aware of this and ensure that people are well educated about cultural practices in those settings. The effort to educate people on different cultural practices can minimise any barriers that may negatively influence

the process of communication. All this is formed by human beings; no culture can exist without humans. Therefore, culture cannot be separated from humans.

2.3.5 Culture and interaction

Ntuli (2012: 20) affirms that during interactions as individuals we often encounter people who not only use different languages but who also come from cultures and backgrounds different from ours. This may contribute to the outcome of a communication process. Chaney and Martin (2011: 5) add that during interaction between cultures, adaptation must take place for the cultures to communicate effectively.

Sorrells (2013: 11) affirms that the cultural dimensions that focus on human interaction are, to a great extent, unconsciously acquired and personified through interaction and engagement with others from one's own culture. Human beings have the ability to establish their own culture, but in order to survive in a new environment and to effectively communicate with others coming from a different culture, both parties' cultural needs need to be accommodated.

Hofstede, Hofstede and Minkov (2010: 12) observe that culture cannot be avoided by anyone, therefore the need to develop shared rules, even if they are never written down, is a pre-condition for any group's survival. Where an individual originates from plays a huge role and is likely to dictate how that individual will interact with others. Through engagements with others from their own culture, people are influenced by the cultural practices that are acquired from the other individual's backgrounds. A person's background has a great effect on the individual which then becomes portrayed as the accepted norm (Sorrells 2013: 11).

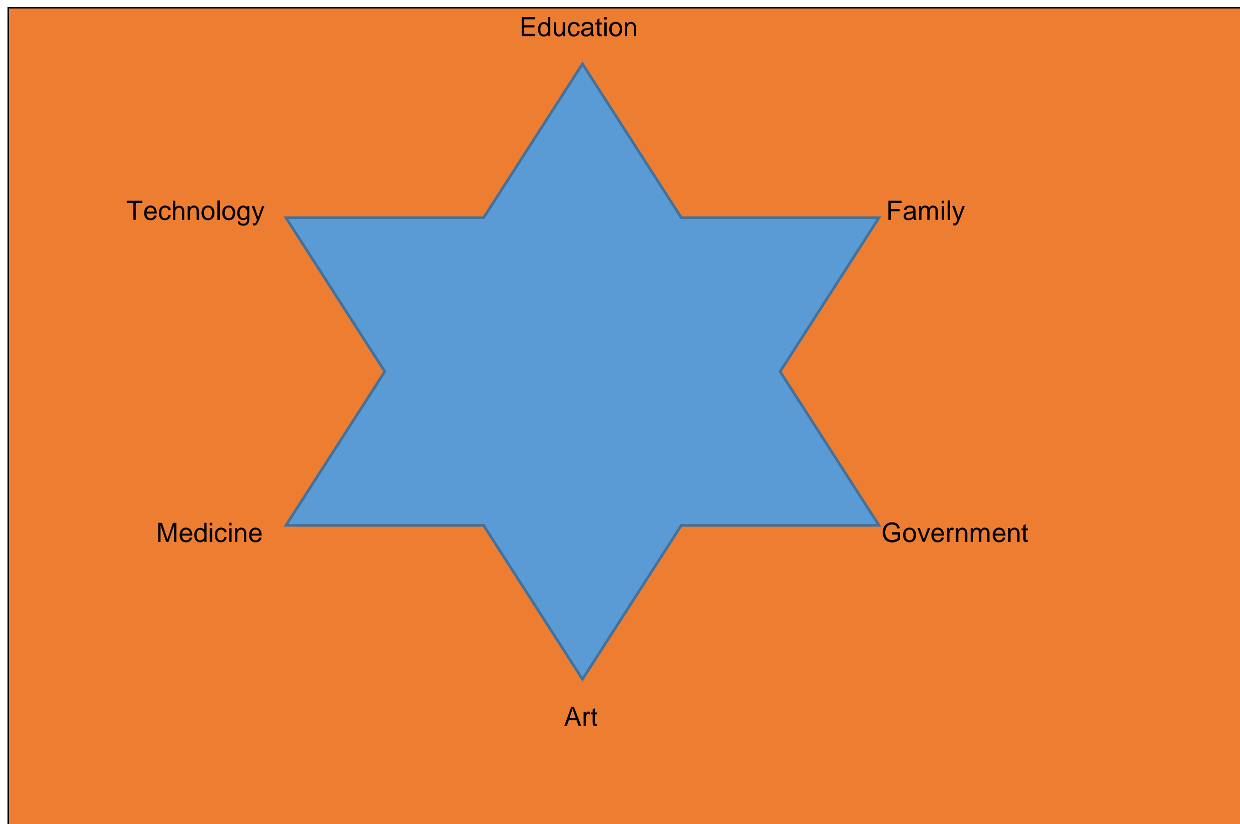

Figure 2.5: Interconnectedness of the parts of culture
Source: Hofstede, Hofstede and Minkov (2010: 2)

Figure 5 only shows some of the factors that form part of and are influenced by culture. The six variables (plus the two which are missing: marriage and tradition) identified in the above figure are made up of rules, principles and values that are developed to guide the process of how organisations should operate.

The rules, principles and values developed in the contexts become the culture which is adopted by members in different contexts for the survival of the group. In the previous figure a connection between the parts that form a culture is not directly shown, however, in relation to the study, it can be explained that education teaches and influences families' lifestyles, government policies, which then affects descriptions and meaning attached to art, which impacts on medicine which is affected by technology advancements.

As has been mentioned by the scholars of communication, culture is very broad. One cannot define culture in a single statement. Therefore, it is imperative to look at various cultural variables which relate to the topic at hand. For this study the focus is on three cultural variables that may affect communication in the health context: race, gender and class. These three variables are involved in all the six variables of culture portrayed in Figure 5.

2.3.6 Race

Cockerham (2013: 152) explains that race refers to a person's observed physical characteristics, with skin colour being the single most important determinant of an individual's racial status. Social opinions concerning the superficial external differences in appearance have resulted in racism which Cockerment (2013: 152) explains to be the belief that one or more races have innate superiority rather than racial bias This is ethnocentrism, which is one of the cultural barriers that that can negatively affect communication. Sorrells (2013: 55) states that race is socially constructed within the contexts of the economy, history, and politics, leading to inequities in societies that continue to impact the present in the context of globalisation. There is no such thing as race, rather there is a human race, scientifically, anthropologically.

Sorrells (2013: 64) confirms that having a certain skin colour can put one in a certain position in society which has certain privileges that go with that position. In South Africa, economic and historical political factors greatly affect race. Consequently, how an individual is perceived based on race impacts the effectiveness of interaction with others. The question is how then the perception of superiority basing on race affect the treatment of patients in hospitals as well as clinics, and does the treatment a patient receives from a health care worker, as well as the attitude the worker receives from the patient ever differ based on what race both parties are from.

Race greatly influences interactions, since the effectiveness of the process relies on how individuals participating in the communication process perceive one another. In the history of South Africa in regard to race during the apartheid era, certain races

were labelled, classed in certain categories and stereotyped based on the colour of the skin. This negatively impacted the social, political and economic variables of South Africa as well as the health care system.

Cockerham (2013: 157) states that the merging of economic, cultural, political and social variables impacting on health along racial lines makes race important. This suggests that race is an imperative element that affects the global, national and local factors, which contribute to a country's success.

Prejudice and stereotypes based on race are to a certain extent displayed during interactions. However, it is not only race prejudice that affect human interactions, it is class prejudice as well, which is also associated with social superiority.

2.3.7 Class

Cockerham (2013: 87) is of the view that class remains the primary determinant of social stratification. Cockerham (2013: 87) adds that medical sociology studies have invariably found strong links between class position and health. Health professionals may treat a patient in a certain manner due to how a patient is classed, or rather the class which they are from. The treatment that people grouped as a certain class receives varies depending on the greatness of attributes that allows them to belong to a certain class.

The classes may range by settings. Cockerham (2013: 90) defines social class as a group of people who have approximately the same amount of wealth, status, and power in a society. For the purpose of the study, the focus is on the social class, since communities' play a huge role in how one is treated based on class, which is normally categorised by what an individual owns, their background, race, gender, age, wealth and the influence they have in the society.

Cockerham (2013: 90) affirms that personal opportunities and life experiences are a form of social inequality that limits individuals in very powerful ways. Furthermore Cockerham (2013: 128) explains that "class distinctions underlie cultural practices, as

particular classes reflect their own particular cultures." A question that develops from this is: how does the culture formed by the group affect communication with other groups. Scholars of communication and culture have indicated that in order for a group to survive certain cultural norms must be developed. Therefore, it is expected that a group of a certain class will develop its own culture to sustain the group.

Cockerham (2013: 162) supports that racial effects are challenged by the power of class position. This shows the relationship between class and race. The two variables affect each other because of the power they both have over the other. A class, race of a certain gender may be treated differently considering the gender of the group.

2.3.8 Gender

Cockerham (2013: 138) states that age, gender, and race are not only characteristics of individuals, but they are also characteristics of particular populations that have consequences for health factors. Age and gender produce health outcomes by way of cohort effects and socialisation and experience.

Dreachslin, Gilbert and Malone (2012: 220) raise an important factor that not all members of an identity group such as race, gender, experience their membership in that group in the same way. This indicates that experiences that an individual encounter in the groups they are part of may be based on one of the cultural variables mentioned. It is possible that different genders have different beliefs, because of their gender. It is possible also those different genders get distinct treatment: men can be treated with more respect compared to women. Woman may have different views, thoughts and attitudes towards a certain topic, while men may have their own. This is a result of the difference in cultural backgrounds, traditions and teachings passed from generation to generation.

Gender roles is where individuals are assigned to perform certain duties and roles because of their gender. Eventually that affects how they communicate certain cultural symbols, depending on the setting. Some races believe that all social activities regardless of the gender should be performed equally, whereas others regard men as

superior and should not perform some activities and those activities are expected to be performed by females, sometimes it is vice versa. The experiences and beliefs can have either negative or positive implications on social interactions.

Race, class and gender are described and communicated using language which can be either verbal or nonverbal. Without language the cultural variables of race, gender, and class would remain as symbols without meaning. The most obvious verbal communication difference between two cultures is language, Zheng (2009: 22). This study does not focus on language, except where, in order to communicate culture, a certain language is used.

Depending on the context where an interaction occurs, the language used may be nonverbal or both nonverbal and verbal. Language enables communicators to communicate attitudes and practices. In addition, language can be associated with culture and society, as the background of these affects an interaction. Nizegorodcew, Bystrov and Kleban (2011: 16) concur that language is the primary means of communication; it is the instrument of culture.

2.3.9 Society and culture

Society plays a huge role in determining which cultural norms should be practised and which signs and symbols should be used to communicate to people and how they are to be utilised.

Sorrells (2013: 12) indicates that dominant cultural groups in societies are often ignorant of the fact that cultural variables (norms, values, practices, and institutions of the society) are deeply designed by, and instilled with, a particular cultural orientation that becomes a pattern of mutual understanding which normalises the way things should be.

The description by Sorrells (2013: 12) is an important factor that societies need to take into consideration, since a society has a great effect on how cultural orientations should be. Social interactions play important roles in teaching people how to relate

with others at different social events. Social interactions serve as negotiations between characters performing within a particular social context to convey aspects of their identity (Danah 2002: 20) Therefore this confirms that it is important to understand the social background of the individual one is interacting with, as it is likely to influence the worldview of that individual.

Paulston, Kiesling, and Rangel (2012: 316) affirm that cultural differences emanating from different social and racial backgrounds influence the way one understands one's reality in an attempt to create meaning from social reality. This can be related to social identity theory which is simply described as a person's definition of themselves which is influenced by their surroundings. Liu *et al*. (2011: 77) explain that the way we perceive and fulfil our social needs is influenced by our culture; people from other cultures may meet each other's needs for inclusion, control, and affection differently.

Liu *et al*. (2011: 176) state that initiating and maintaining personal and social relationships with others is an essential part of life. This is caused by the fact that whenever people come into contact, they share personalities and cultural symbols through communication and those are influenced by their cultural backgrounds. Maintaining social relationship is vital as it provides an individual with a sense of belonging and also creates self-awareness within. Self-awareness allows individuals to have a sense of who they are in relation to society and culture (Danah 2002: 21).

Hofstede, Hofstede and Minkov (2010: 6) support the notion that culture is derived from one's social environment rather than from one's genes. Ntuli (2012: 20) asserts that one's culture is learned from one's own people and this itself is the difference found in various cultures – cultures passed on through socialisation. Liu *et al.* (2011: 176) supports that we are connected to others in a variety of ways through social groups, ethnic communities, friendships, family, organisations, online networks and we define ourselves and evaluate others through these relationships.

From the above literature it is evident that the culture one forms personally is somehow in line with the social culture as they both influence one another. The relationships an individual form with others can influence their own perception of themselves and the

manner in which they communicate and relate with others. Cockerham (2013: 128) urges that the culture of a society is reflected through the knowledge, beliefs, values, customs, and behaviours that the people of that society share.

Casmir (2013: 14) affirms that culture is constantly being developed and recreated in our daily lives in ways which compel us and allow for creativity, which requires flexible people who are able to accept change and adapt. Casmir (2013: 15) concurs that “culture provides for sharing of communal memories and social identity that equal to community”. When a social identity has been given to a person and shared memories established a connection is developed between the two so obviously the extent of effects held over each other is great. Whatever the individuals do after they form a culture, their attitudes and behaviours become their cultural practices.

Cultural practices are manner in which a certain group from certain background conducts thing, that which may be unfamiliar to foreigners outside that environment (Holliday 2013: 6). As a result, cultural shock may be experienced, due to an individual entering a new environment with its own cultural practices and finding it difficult at first to adapt and accept the new rules, values and norms, that are different from what they are used to. It can be expected that a person be in shock and unable to quickly adapt to a new environment and experience. New experiences normally make people uncomfortable, and it takes them longer to adjust and accept the change. Scholars of communication and culture refer to such an occurrence as cultural shock. Therefore, the individual entering a new culture, at some stage will need to be aware of the components that develop and transform social memberships.

Casmir (2013: 15) further sustains that components develop, retain, and change social attachments and culture is not merely a membership but identity. The primary reason why people enter into a new environment is to either acquire information or to become part of that society. Although an individual may enter into a new culture to acquire information, a relationship is bound to be formed. The relationship formed thereafter makes one want to have some sense of belonging. The most important act is to be aware of who creates the cultural practices.

As mentioned above, culture is practised by individuals who occupy that specific environment and generally the spaces are referred to as communities, which is the society occupied by different individuals that make out a single culture, for the success of the relationship. Casmir (2013: 15) confirms that culture implies community, communities that exist at all levels of human society.

A community is also defined as a system that is largely dependent on human interaction and includes standards for proper and effective human interactions (Casmir 2013: 16). Societies influence how an individual perceives other cultures that are different from their own, as culture is learned and transmitted from one person to another. This commonly leads to prejudice, which can hinder communication since an individual becomes selective regarding information provided, because of the societal influences on which culture is right and how certain cultural symbols should be communicated. The information that emanates from the literature on culture and society indicates the influence of environment on culture.

2.3.10 Environnent influences on culture

Samovar, Porter and McDaniel (2010: 24) affirm that the core idea of culture is to make life easier for people by teaching them how to adapt to their surroundings. The surroundings range from environments, community, society and all the symbols that can be in a place that an individual occupies. Chaney and Martin (2011: 6) add that through perception culture is learned, and that perception is formed in various ways: the language learned, birth place, the environment and the people with which one lives with and the psychological motivations we encounter. These environments may be referred to as cultural environments.

Holliday (2013: 6) explains cultural environments as geographical entities from which an individual derives a sense of cultural identity at a particular point in time while cultural practices are ways of doing something which relate to particular cultural environments and may therefore be unfamiliar to newcomers. This indicates that environments are usually occupied by living beings that formulate their own culture in order to make sense of the environment and to be able to operate in it, while everyone

understands the messages sent across through communication that translates the cultural symbols the individuals had formed. It can then become a challenge for a person who is not from the same environment to adjust and understand the rules and customs of the culture practised in that particular environment.

Liu *et al*. (2011: 48) state that difficulties may arise when we try to share meaning with people whose communication behaviours are governed by cultural rules that are different from our own. From these environments identities may be created, based on culture and they are referred to as cultural identity. Note that this is where an individual is first exposed, so they first discover who they are through being influenced by the cultural practices of that environment. Sorrells (2013: 11) defines cultural identity as our situated sense of self that is shaped by our cultural experiences. Once the identity is formed individuals may require some form of system they can utilise to communicate. It is through intercultural communication that individuals can effectively communicate regardless of the difference in cultural backgrounds.

2.4 Intercultural communication

The type of communication that allows people from different cultural backgrounds to communicate is referred to as intercultural communication. It involves people from diverse cultural groups and requires them to be in the presence of each other (Jandt 2013 18). Intercultural communication is also explained as a type of communication that involves interaction between people whose cultural perceptions and symbol systems are distinct enough to alter the communication event (Samovar, Porter and McDaniel 2010: 12).

Living in a global environment which is occupied by diverse individuals from different backgrounds it is imperative to be culturally sensitive of the diversity, to achieve effective communication. The different backgrounds that individuals originate from influence the manner in which they communicate with others. The population in South Africa comes from different cultural backgrounds with diverse cultural variables.

Jandt (2013: 45) concurs that that it can be difficult for the source and receiver in different contexts to share symbols; the source and receiver may need to be in one context and he adds that this is one way of defining intercultural communication. Jandt (2013: 45) explains that intercultural communication requires interaction which needs both the sender and receiver to be in one context, sharing cultural symbols. All communication arises out of interaction with others (Scollon, Scollon and Jones 2012: 171). Being in one setting can assist the communicators to effectively transmit messages that can be comprehended by both parties, as they will both be present to explain any confusion that may prevail. The definitions of intercultural communication have directed that no communication can take place when there is no party that is willing to take initiative to be involved in the communication process, which is interaction.

Paulston, Kiesling and Rangel (2012: 67) affirm that interaction encourages an ongoing process of negotiation, which captures what others intend to convey and also monitors how one's own contributions are being received. People from diverse backgrounds possess different messages that are prejudiced by their cultural backgrounds which they may disseminate differently according to their own style of communication, this may cause a threat during the interactions. Individuals involved in a communication process need to have a mutual understanding, so that the output of the communication process will be mutually beneficial. Intercultural communication encourages this.

MacDonald and O'Regan (2012: 1006) explain that the major purpose of intercultural communication is to encourage a mutually beneficial relationship between the sender and receiver that will promote negotiation among different cultures in such a manner that it does not only combine the people from the same community but also those who are not. Therefore, intercultural communication can be regarded as an effective type of communication that has an ability to allow the parties involved in a communication process to communicate effectively, regardless of their cultural divides.

MacDonald and O'Regan's (2012: 1006) explanation summarises what intercultural communication is about, the effectiveness of the communication. It also highlights the

major role of intercultural communication. There is a necessity to implement intercultural communication in order to avoid miscommunication caused by cultural diversity.

Intercultural communication is regarded as a valuable type communication, explained by the fact that it unites individuals with different perceptions, worldviews, beliefs and ideas, allowing these individuals the privilege of sharing these philosophies efficiently and in harmony. Ntuli (2012: 20) states that what individuals do during interactions among each other is influenced by their traditional pasts. Therefore, it is important for the people involved in the cultural communication experience and practice to be aware of differences to avoid any possible conflict.

According to Asante, *et al.* (2013: 52), there were advances in the 1990s in the field of intercultural research, but the field is still challenged by obstacles of the past that continue even in the present time. These challenges include: the economic development of a country, world religion and co-cultural devoted specialists and are also firmly grounded in the process of intercultural communication.

South Africa has the unfortunate history of apartheid, and many of the circumstances of that era are still prevalent in the post-apartheid era. The country's development has been affected by the factor that caused the majority of citizens of South Africa to suffer during the apartheid era. Although the South African government is making some progress on improving living conditions, the previously disadvantaged groups (blacks, women, and disabled people) are still facing many challenges. Race and gender are issues that in the past have been negatively affected by apartheid, and even in the present time these are cultural variables that are still problematic.

2.4.1 The characteristics of intercultural communication

Within intercultural communication there are characteristics that assist communicators to effectively transmit messages among themselves. These features need to be carefully considered in order to achieve effective intercultural communication.

Adler and Rodman (2009: 18-19) identify the following four intercultural communication characteristics:

1. Motivation, which refers to the desire to communicate successfully with strangers.
2. Intercultural communication allows for open-mindedness to uncertainty that makes it possible to embrace and accept the messages that characterise intercultural communication which are often confusing and sometimes absolutely unintelligible.
3. Open-mindedness which involves the ability to compromise deeply held beliefs about what is right.
4. Knowledge and skill that refer to the ability to get to know other cultures and acquiring the necessary skills needed to be able to interact with them.

The characteristics provided by Adler and Rodman (2009: 18-19) provide a detailed understanding of what intercultural communication is. Being aware of the characteristics when communicating with individuals from different cultural backgrounds will assist communicators to acquire the intended messages to avoid conflicts.

There are a number of problems that occur when individuals who are engaging in the process of communication fail to take the attributes of intercultural communication into consideration. Samovar, Porter and McDaniel (2009: 410) identify the potential problems that may exist in intercultural communication: racism, prejudice, and misuse of power to name a few.

The above-mentioned problems may cause ineffective communication during interactions between individuals from diverse backgrounds. Pearson *et al.* (2013:19) affirm that difficulties may be generated in people's interactions when they have different viewpoints about communication. The problems arising from any form of communication affect the process; communication scholars refer to these as barriers. However, intercultural communication may minimise such problems, which implies its relevance.

2.4.2 The relevance of intercultural communication

The definitions provided by scholars of intercultural communication highlight its importance to communication. For the relevance of this study, it is necessary to fully understand why it is significant in the 21st century to be aware and to be able to comprehend the diversity of traditional backgrounds. Pearson *et al*. (2013: 141-142) identify the following five reasons why it is crucial to learn intercultural communication:

1. The interest an individual may have about other people requires an individual to learn about other cultures out of curiosity.
2. To increase common understanding and sharing of cultural symbols with the people from other cultures.
3. It permits and increases communication across international borders, which thereafter minimises miscommunication caused by globalisation.
4. It allows for better understating of the merging of technologies.

The factors explained by Pearson *et al*. (2013: 141-142) identify the areas where intercultural communication is imperative. Intercultural communication permits individuals to comfortably communicate with others from different backgrounds, on all levels, and also enables these individuals to acquire the necessary information that assists them in achieving mutual and effective relations.

According to West and Turner (2011: 88) the following reasons necessitate the understanding and awareness of intercultural communication:

- Imperative technology, the changes in technology include innovations and advancements which increase opportunities of intercultural communication.
- Commanding demographic, that is diverse cultural backgrounds providing individuals with differing insights, which results in people from different countries coming together.
- Dynamic economy, where populaces in commercial settings, trainings, governments and media communicate with diverse cultures. This relates to health care institutions, research has shown that in South Africa as it is a rainbow country, in a single health care environment people with diverse

cultural backgrounds do come into contact, either working for the same institution or serving patients.

- Imperious peace, which believes that accepting incompatible opinions helps individuals live peacefully with others.
- Self-awareness imperative, allows human beings to be individually conscious of own perceptions and those of others, which could certainly assist in sustaining the cultural dissimilarities in relationships.
- Principled imperative, having to ensure that traditional behaviours are positively portrayed. This means that societies should have an ethical obligation to ensure that they are well informed and completely recognise other practices of culture prior determining the enforcement of their own cultural will upon others.

The above reasons highlight the role of intercultural communication in the organisation and societies at large. Byram (2000 cited in Nizegorodcew *et al.* 2011: 16) found that intercultural communication aims to reveal the external and internal relationships between different cultures, interpreting each in terms of the other, as well as being able to analyse and critically understand both native and alien cultures.

Liu *et al.* (2011: 188) affirm that in today society, it is more likely that we live with culturally different beings in our own towns and countries; hence developing good intercultural relationships becomes a significant part of life. Liu *et al.* (2011: 188) explain that intercultural communication goes as far as foreign affairs. Therefore, being culturally aware is vital in today's global village - this is what intercultural communication is for the reason that it has strong effects on communication. However, intercultural communication can be hindered by barriers that potentially affect the success of the communication.

2.4.3 Intercultural communication barriers

Jandt (2013: 82-86) identifies the following four barriers of intercultural communication:

1. Anxiety, which refers to being anxious due to not knowing what you are expected to do.

2. Supposing similarity instead of difference, which is to assume that there is no difference existing between cultures.
3. Ethnocentrism which is undesirable i.e. making conclusions about other people's cultures based on one's background experiences.
4. Prejudice and stereotype refers to placing judgements on others because of their differences to one's own identity, affiliation to certain groups and unreasonable aversion.

The previously mentioned complications are the result of the requirement of cultural background change. Change of any nature can result in extreme anxiety, regarding the exposure of this nature. Contact with another culture can evoke skepticism, fear, and defensiveness both in face-to face contact and remotely (2011: 15). Intercultural communication barriers may affect communication between a healthcare worker and a patient.

Other barriers to intercultural communication are: anxiety and ethnocentrism, which occur because when an individual gets exposed to a different culture from their own, they judge the aspects of that culture by the standards of their own culture since they usually do not know what is expected of them. Anxiety can be related to cultural shock as they may have similar responses.

Chaney and Martin (2011: 72) define cultural shock as the disturbance that one experiences when one changes to beliefs diverse from one's own values and principles. Anxiety is associated with being anxious due to not knowing what is expected from one's conduct (Jandt 2013: 82). A patient entering into the health care setting, for a first time, may experience cultural shock and anxiety. Thereafter, the communication between the parties will be affected, as the patient will not be aware of what is expected of them, which results in a form of disturbance. It is clear from the definitions of the two terms 'anxiety' and 'cultural shock' that an individual can experience negative psychological effects, when in a different situation with no rules on how to behave. Chaney and Martin (2011: 73) state that many problems may develop and affect an individual's comfort zone because of cultural shock.

Another barrier of intercultural communication that may have a greater negative effect on the communication process and which also may have similar responses, is ethnocentrism. Jandt (2013: 85) explains that extreme ethnocentrism excludes other points of view and lead to the refusal of exchange of ideas and skills among peoples. Chaney and Martin (2011: 10) say that ethnocentrocists believe that their culture is the central culture and other cultures are incorrect. This is a personal belief influenced by what a person has been taught and experienced. It is part of who they are as an individual, which is displayed through self-disclosure through introspection and socialising.

The main personal traits that affect intercultural communication are self-concept, self-disclosure, self-monitoring. Self-concept refers to the way in which a person views the self. Self-disclosure refers to the willingness of individuals to openly and appropriately reveal themselves to their counterparts. Self-monitoring refers to using social comparison information to control and modify one's self-presentation (Jandt 2013: 35). The manner in which an individual presents himself or herself is influenced by cultural beliefs and background. It then becomes a challenge when the individual has to enter into a new environment which requires them to be aware of and accept that there may be change that may require adjustment and adaptation.

Change is not easily accepted and can result in extreme anxiety. Anxiety and ethnocentrism may be the main barriers to intercultural communication, because when an individual gets exposed to a different culture from their own, they may judge the aspects of that culture by the standards of their own culture and they will not know what is expected of them.

2.4.4 Intercultural effects on communication

Communication is a process that allows interaction between individuals and there are certain effects that contribute to the success or failure of the communication process. The effects can be either negative or positive. The positive and negative effects of communication determine whether a mutual agreement is reached, while they can also

determine if conflict is created based on the extent of misunderstanding between the people involved in the communication process.

Hamilton (2010) explains that language and culture can negatively impact on the achievement of the contact during intercultural communication; when this occurs in professional settings, misunderstanding and communication breakdown can have serious implications. As intercultural communication is described by communication scholars as communication among people from diverse cultures, it is evident that culture has an impact in the communication. Cultural differences affect intercultural communication. Depending on the extent of awareness of the people interacting regarding the differences between them, the interaction can be positive or negative. The outcome of the interaction depends also on identity, which can be developed, or rather, displayed, during intercultural communication, which is a crucial significance of who an individual is. The manner in which a person identifies themselves as, and how that is presented to others is important in establishment and development of intercultural relationships.

Pearson *et al.* (2013: 145) affirm that intercultural relationships are stalled by many perceptual misrepresentations, self-communication and observation. Self-communication is personal communication (thoughts). Intercultural communication can have advantages that enable culturally diverse groups to communicate. To be able to identify the advantages, the communication characteristics need to be known, explained and understood by individuals who are and those desiring to engage in an interaction with others.

2.4.5 Identity and intercultural communication

According to Samovar, Porter and McDaniel (2010: 153) identity is an essential part of the study and practice of intercultural communication; therefore, it needs to be completely apprehended. This may suggest that the development of identity has the potential of playing a crucial part in the individual's mental and emotional well-being, which necessities understanding of this fact, since this understanding can be outwardly self-evident.

In addition, Samovar, Porter and McDaniel (2010: 153) confirm that the major concern in the study of intercultural communication is how roles of human beings, which are sending and receiving messages, are provided by guidelines (cultural signs and symbols) for interaction with others are identified and influenced by identity. Samovar, Porter and McDaniel (2010: 155) add that identity is dynamic and multiple: it is not static, but changes as a function of life experiences. Individuals need to be of aware of their own uniqueness that sets them apart from others but also take into consideration the uniqueness of others to eliminate any misunderstanding and to completely enjoy the benefits of intercultural communication. The main reason for the acknowledgement of the differences in identity is to avoid losing a sense of belonging because of the ever-changing environments occupied by human beings. In a country like South Africa where different cultures exist the recognition and acknowledgement of identity is vital to achieve successful intercultural communication.

Turner (cited in Samovar *et al.* 2010: 155) identifies three classifications of identity:

- Human identities.
- Social identities.
- Personal identity.

Human identities are self-perceptions that link one to the rest of humanity and they set one apart from other life forms, whereas social identities are represented by group membership, including race, status, and age, while personal identity arises from the uniqueness one has compared to others.

Identity to a certain degree affects communication between individuals who possess different personalities shaped by their past experiences because it influences interaction through determining expectations and encouraging a certain behaviour (Samovar, Porter and McDaniel 2010: 167).

According to Samovar, Porter and McDaniel (2010: 167) “in an intercultural meeting, the varying expectations for identity display and communication style carry

considerable potential for creating anxiety, misunderstandings, and even conflict". The authors elaborate that in an intercultural gathering, the varying anticipations for identity display and communication style carry substantial potential for creating unease, which can lead to conflict.

After identity has been established and recognised, the challenge may be how the individuals possessing different identities can communicate effectively. The necessary skills to communicate effectively must be adapted; in intercultural setting individuals need to be culturally competent to achieve positive outcomes from the communication. This is known as being culturally competent, which will be discussed in the next main heading. However, communicators need to note that intercultural communication can take place in any context, where people are willing to communicate, regardless of the cultural diversity.

2.4.6 The sectors where intercultural communication is practised

In schools, churches and professional settings including health care centres, intercultural communication has to exist and be practised since the individuals who occupy such spaces generally come from diverse cultural backgrounds. If the cultural differences are not recognised and appreciated, problems relating to intercultural communication may occur. A health care context requires one to be interculturally competent in order to achieve effective communication with other individuals from different cultural backgrounds from one's own.

2.4.7 Intercultural competence

Cultures differ, so sensitivity to and understanding of another culture is a requirement for successful communication (Nizegorodcew *et al.* 2011: 15). A competent intercultural communicator understands that people are diverse in thinking, beliefs, and behavior, which is commonly influenced by culture. Therefore, to communicate effectively with individuals who have a different culture from one's own, one needs to

be sensitive and aware of these differences. Such awareness is known as intercultural competence, which is vital for successful communication.

Samovar, Porter and McDaniel (2010: 167) concur that "intercultural competence occurs when the avowed identity matches the identity ascribed" which require the principal components of intercultural communication: knowledge, motivation and skills. To achieve intercultural competence, an individual should be exposed to learning in order to acquire the necessary knowledge and be motivated to use it accordingly with the relevant skills of communication.

Jandt (2013: 8) states that having the ability to be tolerant while appreciating diversity is a requirement for a competent communicator in multicultural settings.

2.4.8 The theoretical underpinnings for intercultural communication: cognitive dissonance theory

In this theory, the dissonance begins with the notion, thought, idea and so forth of a communicator (Littlejohn and Foss 2008: 78). The concepts are then communicated to others. This suggests that a person enters into a communication process with already held notions which they transmit to others through communication. This theory is relevant as this is an intercultural study. Individuals in an intercultural context need to be aware that people come into an environment with their own concepts and that communication begins with self (personal thoughts).

Uncertainly Reduction Theory

According to Hofstede (2016: 42) uncertainty reduction theory suggests that when strangers meet, the primary focus is on reducing their levels of uncertainty in the situation. The levels of uncertainty are located in both behavioural and cognitive realms. They may be unsure of how to behave and how the other person will react to that behaviour. Therefore, strangers may also be unsure what they think of the other and what the other person thinks of them. Furthermore, people's uncertainty is on both

the individual level and relational level. However, it is vital to note that media plays a huge role in creating messages that create uncertainty among individuals. Most people consume vast of knowledge from the media, on any day and on any topic. Hence, the media cannot be ignored, nor be excluded under any topic, that is socially relatable. The extent to which the media is relatable to people, tend to lead to certain living expectances, which comes naturally to human beings; the media somehow provides people ideas of how certain ideologies may be practised, in this way it helps model to people how to make sense of some thoughts and how to project those to others.

Expectancy violation theory relates to the uncertainty reduction theory. Expectations come with various feelings, which can lead to certain behaviours. Unexpected behavioural change of people while interacting is explained by expectancy violation theory (Mishra 2017: 1).

It is human nature to expect people to behave in certain ways during any conversation which is often violated due to the relationship status of communicators, the situation they are in, or their mental state. "The violation is sometimes taken to be positive whereas sometimes it is negative according to the situation and the people involved. Individual perceptions, culture and behaviour varies from person to person which also makes their communication patterns peculiar" (Mishra 2017:1).

For instance, there can be a topic on Facebook about racism in private hospitals. If the comments on that topic defend patients of a particular race, from health professionals of another race, the person sitting at home and scrolling down on the newsfeeds, and having never been in a private hospital, will now have that expectation of race relations as fed by the media. The manner in which the person behaves when they come into contact with a health professional of the race mentioned on the social media platform will be based on the information received from that platform. Therefore, the media had set the agenda.

Agenda-Setting Theory

According to Steinberg (1994: 133) agenda setting refers to the events and levels that the media undergo to create concern and awareness about key issues which then shape public opinion. The media influences and shapes the perceptions of the public which explains why they attach meaning to certain issues and how they react to them.

Steinberg (1994: 133) adds that the theory proposes that the media selects topics and communicates them to the public in a such way that the public then considers them to important. Therefore, whatever the media deems as not important the public is most likely to also believe that it is not important. When it comes to health care the media also plays a huge role in creating awareness on which health issues should be considered as important and how people should take care of their health. However, it comes down to how an individual identifies who they are. This helps communicators to be able to accommodate certain topics, while reducing negative influences caused by differences.

Identity-Negotiation Theory

According to Swamm and Bosson (2008: 448), identity negotiation is a process through which people who fail to receive nourishments of their identities, work to obtain nourishment for their identities, Samovar, Porter and McDaniel (2010: 167) state that in intercultural communication, the different expectations of communication style and identity display carries considerable potential for creating conflict which could be the result of misunderstandings and anxiety.

Swamm and Bosson (2008: 452) identify three identity needs that play a role in the identity negotiation process:

1. Agency – encompasses feelings of agency and competence.
2. Communion – encompasses feelings of belonging and connectedness.
3. Psychological coherence – encompasses feelings of regularity, predictability and control.

Identity negotiation relates to health care, as patients who require the services, need to be fully aware of what kind of care they are receiving. Health care workers need to be aware of the needs mentioned by Swamm and Bosson (2008: 452), to avoid conflicts of interests between them and patients. Thus, health care professionals as well as patients may have to understand how to accommodate one another, regardless of the differences in race, status, and language. Therefore, the knowledge of communication accommodation theory becomes crucial.

Communication Accommodation Theory

Related to social identity theory, communication accommodation theory is about people adjusting to communicate by minimising social differences. According to Mishra (2017d), this theory proposes that people want to portray their positive identity to others. The theory describes the human tendency to adjust their communication according to situations and the people involved. Furthermore, it raises the impression that individuals have the ability to control social differences through adjusting themselves to different kinds of situations. In addition, it proposes that people try to get approval for everything they say and do by creating a positive image of themselves in front of the other communicator.

2.5 Importance of health care

Health care is an important part of a human life. How an individual takes care of his or her health can determine the length of the life that individual may live. Individuals use different measures and methods to take care of their health. The measures and methods taken depend on the individual's beliefs and views, which are influenced by their cultural background.

Rowe and Moodley (2013: 1) state that health care is a universal human need and cannot be considered a mere commodity This is vital for all human beings to comprehend; both the health care workers and patients need to be aware of this. Health care is a necessity for all living beings. This study focuses on human beings and not animals, plants and other living beings. Therefore, the focus is on health care

facilities that offer services to human beings and are normally referred to as hospitals or clinics.

The Colorado Patient Navigator Training Program (2011: 1) explains that a hospital system is a group of facilities that delivers services to their communities through working together, and diverse hospital systems have different types of financial goals and ownership. The Colorado Patient Navigator Training Program (2011:1) defines the following types of hospital systems:

- **Public Hospitals**

  Public hospitals are funded and owned by local, state or federal governments and receive money from the government. Some public hospitals are associated with medical schools.

- **Non-profit Hospitals**

  Non-profit hospitals are often community hospitals and may be linked with a religious denomination. The main goal of a non-profit hospital is to provide service to the community.

- **Private Hospitals**

  Private hospitals are owned by investors. Their goal is to earn a profit. Private hospitals tend to offer more profitable services such as rehabilitation, elective or plastic surgery or cardiology. They try to avoid unprofitable services such as emergency medicine, which can lose money due to uninsured patients.

South Africa has both private and public health care systems. Rowe and Moodley (2013) concur that currently South Africa has a pluralistic health care system which separates private and public sectors. Furthermore, with the introduction of the National Health Insurance initiative, South Africa is moving towards a socialised model. The South African legislative environment has changed recently with the proclamation of the Consumer Protection Act which means that from a legal perspective, patients are viewed as consumers, according to proposed amendments to the National Health Act that (Rowe and Moodley 2013).

Anell (2015: 1) states that there is no evidence that the quality or efficiency of private providers differ significantly from those of public providers — nor should such differences necessarily be expected, since providers' responsibilities and payments are the same irrespective of their ownership.

2.5.1 Private and public health care

Corporate capital stimulated the development of the private health sector and private hospitals which were previously limited to mission hospitals and industry-specific facilities, (Coovadia *et al.* 2009: 9). This limited access to certain individuals that were economically privileged and held prominent positions in society. The question is what happened to the less privileged who could not afford to have access to the private health care services. Although in South Africa most people can have access to the private health sector, it is still a challenge for the previously disadvantaged group. Now there is a private sector which is based on individual purchasing power, and a public sector based on welfare provision.

Private health care limits access to individuals who have money to afford medical aid or to pay directly. Patients who cannot afford the private sector's services, opt for the public-sector hospitals, where the government funds the products and services provided.

One of the challenges is the quality of service rendered to the patients who come in for admissions. Coovadia *et al*. (2009: 9) maintain that problems with the private sector include questions about the quality of clinical care provided by private general practitioners. The quality of services which patients receive from health professionals in the private health sector is to a certain extent influenced by the cultural variables: race, gender, and class. This determines how the communication, which includes negotiation between a patient and a health care professional, will take place.

Dreachslin, Gilbert and Malone (2012: 224) explain that health care encounters involve negotiation, where the participants must establish a common ground and shared purpose and agree to express themselves in ways that are mutually understood and

accepted for a health encounter to be experienced successfully by both parties. Culture plays a major role during the negotiations and interactions between the participants.

Considering that patients are now regarded as consumers, the approach to patients in the private health care sector may be different compared to the approach to patients in the public health care sector. Normally, in any private sector, which can be a company or school – the people receiving the service provided by the institutions expect to be given quality service. Considering a private healthcare centre, patients as consumers will have high expectations, considering that in South Africa private sector services are costly and they will want to receive the highest quality care considering the cost. A consumer pays for a service rendered by a provider – the provider, therefore, needs to be aware of the requirements of the consumer, so that the consumer receives value for their money. The quality of service delivery and how the consumer receives it sets the perception associated with the brand or reputation of the institution. For instance, when a patient (who is the consumer) is satisfied by the service provided by the health care professional (the service provider) the entire experience (the medical process) impacts the perception the patient has of the entire context. Stereotyping exists in this regard; one service between a doctor and a patient can affect how the patient views the entire staff from the health care centre. It is crucial, therefore, that service delivery is well executed to positively represent the context and preserve the credibility of the product and the service provided.

Marais and Peterson (2015: 3) maintain that "health governance concerns the actions and means adopted by a society to organise itself in the promotion and protection of the health of its population, thus, goes beyond the formal mechanisms of government to include the totality of ways in which a society organises and collectively manages its affairs".

According to Schiavo (2014: 3):

> Health communication is an evolving and increasingly prominent field in public health, health care, and the non-profit and private sectors. Therefore, many authors and

> organisations have been attempting to define or redefine it over time. Because of the multidisciplinary nature of health communication, definitions may appear somewhat different from each other. Nevertheless, when they are analysed, most point to the role that health communication can play influencing, supporting and empowering individuals, communities, health care professionals.

Health communication is important because it influences and empowers. Communication cannot be separated from culture, as previously explained. Hence, this study has been conducted to identify the role of intercultural communication within a health care context, focusing on a single context. Health care communication scholars have identified the impact that health communication has on individuals as well on health care workers. This study aimed to critically analyse health communication, which is sensitive to culture, while creating awareness of the health care workers and patients' diverse cultural backgrounds.

South Africa as country is governed by laws in all spheres, including the health care context, so it is necessary that this study discusses some of the sections of the country's Constitution, in relation to health care. The South African Constitution aims to protect freedom of choice and individual rights such as the rights to equality, human dignity, life, freedom and security of the person, privacy, and access to health care (Rowe and Moodley 2013: 3). Health care professionals from both public and private contexts are taught these rights, since they deal with the public, as it is one of the principles that public servants should put people first. Thus, an informed relationship between health care professionals and patients is considered as imperative. However, research studies on health care have indicated that not all professionals in this sphere have the necessary information on patients' rights. The lack of this information can hinder operations within the sector.

Rowe and Moodley (2013: 3) state that ethical health care requires that the patients' constitutional rights are respected. According to the Health Professions Council of South Africa (HPCSA) (2016: 1), being a decent healthcare practitioner necessitates ethical practices, a lifetime commitment to sound professional practice and a dedication to the health interests of one's fellow human beings. The Hippocratic Oath

(Name and Shame, Biz 2000) emphasises how health professionals should put the needs of their patients before their own.

2.5.2 Global health care to community health care

South Africa has prevalent health differences which represent the legacy of apartheid and colonialism while the country's transition to democracy represents the start of an interesting period within the larger context of Africa in its postcolonial era of independence (Rowe and Moodley 2013: 3) This suggests that individuals are free to practise their rights, which involve the right to association and belonging. The right to belonging can be associated to freedom of identity. The freedom of identity suggests that individuals can belong to any culture or group in society, which is differentiated and categorised in different levels. This is described in Figure 2.6.

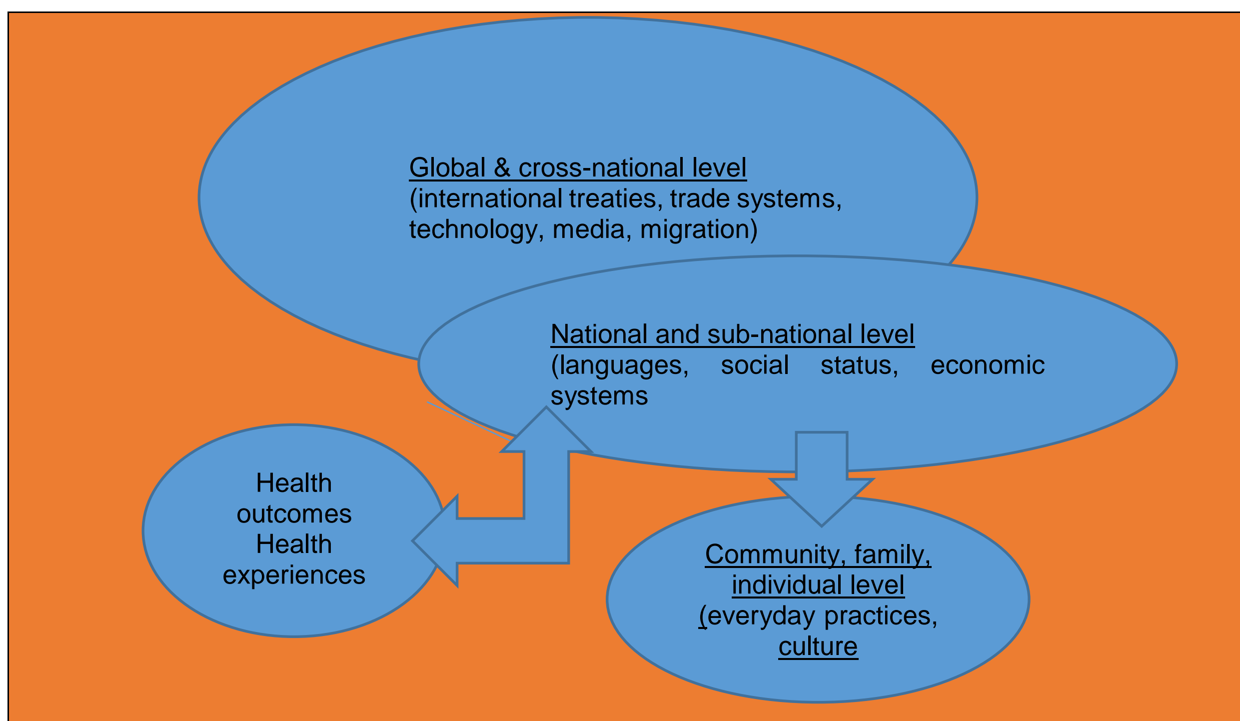

Figure 2.6: The interaction of cultural factors across global, national and community levels that influence health
Source: Banwell, Ulijaszek and Dixon (2013: 5)

Figure 2.6 describes the different levels of health care, from global to community level. Banwell, Ulijaszek and Dixon (2013) suggest that on the global level of health care,

international agreements and contracts are drawn. Figure 2.6 suggests that at an international level, the focus is more on service exchanges of technology: the machines and electronic systems used for medical purposes through the media, which communicates to the migrants (people who are not originally from that place but are from an outside country and are living in a certain area to earn better living). Thereafter, the migrants enter into a new space where the language is new and different from their own, the social status and economic systems of the particular country, which the migrants have relocated to, becomes relevant.

Figure 2.6 further suggests that after laws have been drawn up on the global level of health care, they are implemented at the national level where cultural variables such as language and social status are affected by the economic status of a country.
Finally, the community and the individuals are affected as cultural variables form part of their everyday practices. The cultural variables originating at the national level, influence the community, family and individual level and impact the health experiences and outcomes. In the context of this study, the communicated cultural variables describe identity. Consequently, based on the description provided in figure 2.6 culture exists in any context. Culture plays a major role in that it influences the outcomes and experiences within a health care context.

2.5.3 Culture in the health care context

Hofstede, Hofstede and Minkov (2010: 202) observe that practices and theories of medicine are tightly linked with cultural traditions, in which uncertainty avoidance plays an important role. As the literature on culture indicates, for every setting where people gather cultural traditions are bound to be formed. Hofstede, Hofstede and Minkov (2010: 202) suggest that in medicine cultural traditions are formed to avoid uncertainty. The cultural practices implemented in the health care context enable the patients and health professionals to be able to survive in the context. Therefore, it is crucial that at an early stage when the patients enter the environment they should be made aware of the medical cultural traditions.

The role of culture then will be recognised. Thereafter, the effectiveness of the traditions will be determined through the level of cooperation among the participants. The reason why the participants need to be aware of the effect of culture in the context is that the success of practising the theories of medicine depends on the willingness of the sender and receiver to adapt and accept the cultural diversity.

Napier *et al.* (2014: 1619) identify 12 findings that need attention in the health care sector:

1. Medicine should accommodate the cultural construction of wellbeing.
2. Culture should be better defined.
3. Culture should not be neglected in health and healthcare provision.
4. Culture should become central to care practices.
5. Clinical cultures should be reshaped.
6. People who are not healthy should be capacitated within the culture of biomedicine.
7. Agency should be better understood with respect to culture.
8. Training cultures should be better understood.
9. Competence should be reconsidered across all cultures and systems of care.
10. Exported and imported practices and services should be aligned with local cultural meaning.
11. Building of trust in health care should be prioritised as a cultural value.
12. New models of wellbeing and care should be identified and nourished across cultures.

Based on this, it can be clearly comprehended how culture cannot be separated from the health care context. The importance of culture within the sector is explained by Napier *et al.* (2014). As more research is conducted on these subjects, researchers are considering these factors, and identifying if they are recognised and addressed. It is important that health care centres consider these factors in order to create a harmonious working environment, while achieving effective communication with the patients. According to Napier *et al.* (2014: 1611) it is important to understand how wellbeing is socioculturally generated and understood, and how cultural systems of value do or do not relate to notions of health and to systems of care delivery.

Furthermore, these points are imperative to the advancement of health worldwide and are the greatest challenges for health, since at the level of culture and health, the tendency is logical: when groups find themselves in flux and unstable, the less fortunate are often not met with empathy, but with impatience and disregard (Napier *et al.* 2014: 1619). These are some of the barriers to communication in a health care.

Anand and Lahiri (2006: 392) identify the following cultural barriers in patient care:

- The patient's level of comfort with the practitioner and fear of what the health care worker may find upon examination which may be the concern that the patient's lifestyle and habits may not meet with the provider's approval.
- Difference in understanding, on the part of the patient, regarding the role and function of the health care system and health care providers, which may vary greatly based on cultural context.
- The fear of rejection of personal health beliefs. Patients may face providers who do not respect their beliefs and who may even challenge those beliefs. Given that many of these beliefs are rooted in the patient's spiritual traditions as well as his or her cultural orientation, this is an extremely sensitive issue.

The above challenges have the potential of causing miscommunication, which may delay the medical consultation. Consequently, the intended outcomes will be affected, as the intended messages transmitted could not be properly interpreted by the people involved in the communication process. The previously mentioned barriers indicate the influence of different cultural backgrounds, and what happens when people from different cultural backgrounds come into contact, the fear of the unknown, cultural shock which has been earlier mentioned in the literature. All these affect the interactions in different levels in the health care sector.

Hollard (2017) states that despite the increase in research and data that indicates that religious beliefs and culture of patients are well-thought-out in a health care setting, there is still minimal indication on what is done to accomplish this. There is a great lack of information on how health care professionals care for the patients, in considering and being sensitive to the patient's cultural needs. This requires empathy,

which is a characteristic of a good communicator. Schiavo (2017) concurs that communication about life and death matters requires genuine and informed comprehension of key groups that will be communicated with, moreover, there should be a willingness to adapt and redefine the communication goal, process and strategies on the basis of the intended audience feedback.

In most cases, in health care spirituality is regarded as a crucial aspect of a patient's culture. This is because, illness is associated with spiritual wellbeing. Chandramohan and Bhagwan (2015) affirm that since patients constantly rely on spiritual measures to find healing and cope with illness, care for spirituality then becomes a vital factor for health care professionals bear in mind.

Since spirituality is culturally related, culture cannot be excluded in health care. Culture can be associated with spiritual aspects that may include diverse spiritual beliefs as well as prayer, music, silence, and scents. These are culturally learned and taught. Therefore, in a healthcare setting, the health care professional – perhaps the entire staff within a health care context – need to be aware of patients' diverse spiritualities. To add to what Chandramohan and Bhagwan (2015) state, observation and experience, patients as humans utilise different measures to cope through life, which taking care of one's health is a greater part, in living life. This means that to cope with daily life events, human beings ascribe to comfortable rules and practises to deal with challenges and changes that occur daily.

Research on well-being, spirituality and health, has grown in the Western context, with spirituality revealing itself as an important part of a patient's lifecycle especially when challenged by illness (Koenig 2009: 283). To take care of this part of an individual's life, patients sometime use spiritual healing to survive and be able to deal with the effects of an illness. On the other hand, health care workers are taught the medical material on how to help patients overcome the health challenges, while they may have little information on how they should assist and influence the patients' spiritual sphere; this may cause negative results on the parties' interactions and communication. The key here is how much knowledge do the workers have on the diverse spiritual

dimensions that different patients possess, according to their cultural backgrounds, so as to communicate accurate messages, directly tailored to each patient's needs.

South Africa is the "rainbow nation". In Durban there are Indians, whites, blacks and coloureds with diverse religions. Blacks are the most diverse ethnic group and possess and practise various religions and different spiritualties. Through experience as an African lady, this researcher has an awareness that this group finds it hard to adjust or rather adapt to new settings with practices that are different from their own. This is prevalent in relations with other religions and cultures. For instance, in the black culture there is a tribe that does not believe in Western medicine/medical practices. There is often a conflict of interest between the African medical practices, which are also spiritually connected, and the Western culture.

2.5.4 Communication between health care providers and patients

The Colorado Patient Navigator Training Program (2011: 1) lists the following as members of the health care team:

- Doctors;
- Physician Assistants;
- Nurses;
- Pharmacists;
- Dentists;
- Technologists and technicians;
- Therapists and rehabilitation specialists;
- Emotional, social and spiritual support providers;
- Administrative and support staff; and
- Community health workers and patient navigators.

The relationship built during the interactions between patients and healthcare workers is vital as it concerns life and death. Figure 2.7 shows a diagram which is a simple description of this relationship.

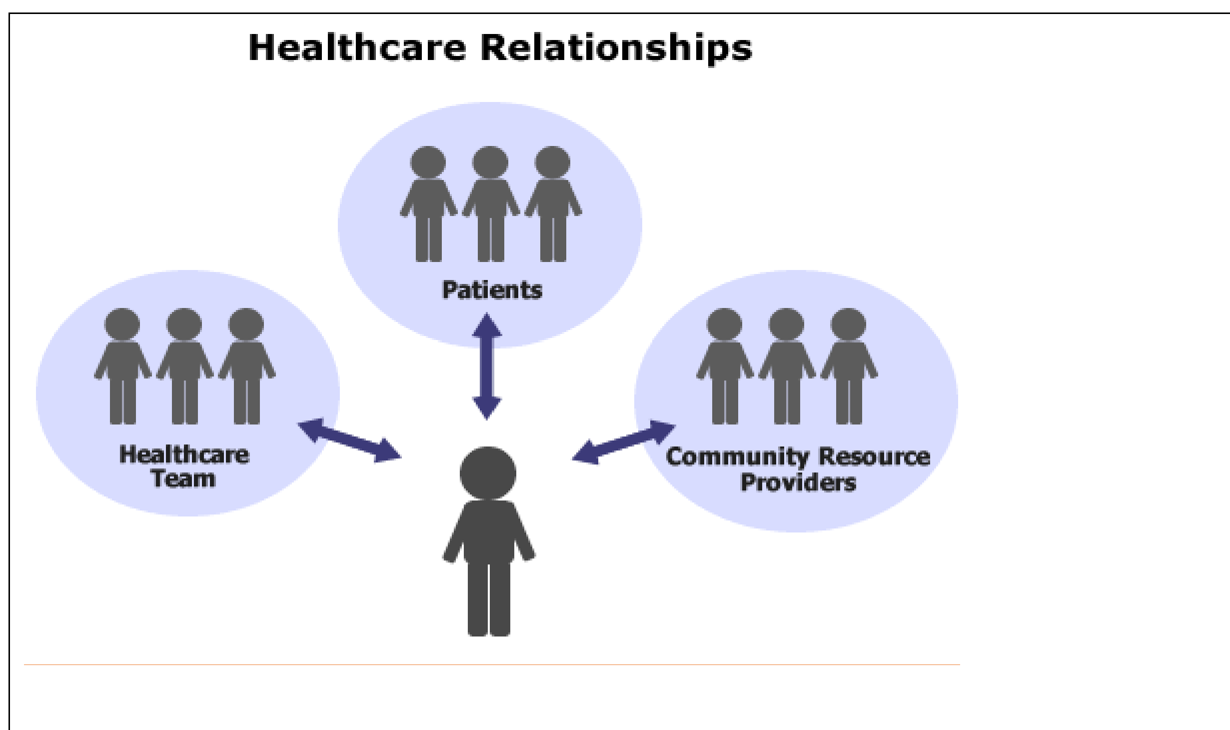

Figure 2.7: Healthcare relationships
Source: Colorado Patient Navigator Training Program (2011: 1)

Figure 2.7 suggests that from patients, health care team and resources received from the community, it all goes down ward to one individual. In the context of this study, the one individual the arrows in diagram 7 point to can be arguably regarded as the government in a public sector or an entity that owns the private health care sector. While the community resources can be considered as the different cultural aspects that are socially influenced – the relationship between doctors, nurses, unit managers are influenced by the one individual who has the power to sanction laws that will govern the operations within a health care context. Thus, the community's level of influence cannot be discounted. From the graph: figure 7 it is noticeably that the rules and regulations that over health care sectors are influenced by the characteristics of the health care team and the patients. This could imply that the health care context can be non-resisted to change, which can be influenced by both the change in behaviour, attributes from the team and the patients.

Mira *et al.* (2012: 827) point out that

> In recent years, the framework of the doctor-patient relationship has undergone notable changes in line with the development of the principle of autonomy, which reaffirms patients' capacity for decision making in all matters relating to their health. This interaction involves attitudes, aptitude and behaviours in the form of, on the one hand, styles of professional practice.

Mira *et al.* (2012) indicate that there should be a possibility of flexibility and change in rules within a health care setting, depending on the attitudes and behaviours of the health care team and patients. It is sensible that the rules that govern the operation within the context should accommodate the parties involved. The interaction includes certain characteristics, attitudes and behaviours in the form of professional styles of practice from the professionals involved and expectations from both patients and health care professionals about the encounters between the health care professional and the patients which are usually predetermined in relation to the outcomes (Mira, *et al.* 2012:827). This concurs with the introduction of this study in Chapter 1 regarding patients coming from their own social norms into a professional space, where there

are rules and regulations set for the space's operations. Therefore, this advances the element of respect of the diverse cultures that exists between health care workers and patients.

Paulston, Kiesling, and Rangel (2012: 318) quote the Crawford study which indicates that communication often fails when the health care provider and a patient do not share a common cultural background. There is the possibility of great danger when communication fails in a health context. A patient with anxiety from societal influences is likely to block out new information received from the health professionals.

To support the above statement, Paulston, Kiesling, and Rangel (2012: 317) go on to say that in the communication event, the specialist does not only occupy a high rank in the hierarchy of communication because of his or her profession or race, but also conducts the examination in a language that is foreign to the patient. The patient occupies a disempowered position that leads to the whole interaction being ineffective, as the patient becomes passive during the medical consultation, thus the outcome of the treatment become less informed.

Doctors are categorised as high-profile people because of their profession and they hold a powerful position in society. They are likely then to have power over patients who are from the society. This power can affect how they communicate with the patients and can lead to doctors neglecting the importance of learning about the behaviours and attitudes of patients that are impacted by their cultural backgrounds. Health care professionals should be aware of their power in the communication hierarchy. In such a context it may be required from the parties involved that they be mindful to avoid possible negative effects or consequences. This necessitate learning the new cultural practices for every new environment that an individual enters.

Paulston, Kiesling, and Rangel (2012: 323) state that the term 'mindful', in essence, requires that one to concentrate on the process of communication rather than the outcome thereof. The concentration on the process can produce a positive outcome.

It is the communication process that is most important as it promotes two-way interaction. To promote two-way interaction between doctors and patients and between health professionals require mastering basic skills in communicating with people, such as explorations of unspoken concerns (Claramita *et al*. 2014: 475). This displays the relevance of intercultural competence in health care.

In addition, Paulston, Kiesling, and Rangel (2012: 324) observe that communication can be very difficult due to the differences between two cultures, which, if there is too much noise, can break down completely. Therefore, the noise needs to be controlled, especially in a two-way interaction, where both the sender and receiver are active, and clear communication is the goal. Samovar, Porter and McDaniel (2010: 358) state that clear communication is an essential component for effective health care delivery. Correct application of communication is necessary in different clinical care phases with patients; it is considered to be central to the clinical abilities of health professionals worldwide (Claramita *et al*. 2014: 475).

Napier *et al.* (2014: 1614) are of the view that the responsibilities of doctors, health systems, and the priorities of policy makers and researchers, are collective behaviours based on social agreements and assumptions which focus on culture. Therefore, the social environment should be considered when forming medical theories. Dreachslin, Gilbert and Malone (2012: 240) state that when health care professionals attribute their own feelings, thoughts, expectations and behaviour to the patient, assuming similarity instead of difference, projected similarity occurs. This could hinder the health care process and the opportunity to acquire new information about other cultures.

Patients are much more willing to bear the burden of their suffering when that suffering has shared meaning. For this reason, health cannot be separated from culture. Indeed, healthcare provision can only be advanced by a reassessment of, and renewed interest in, the role of culture in health. The future of health care lies not only in policy formation, but also in policy implementation (Napier et al. 2014: 1628).

According to Dreachslin, Gilbert and Malone (2012: 219) providers of health care and related services must be responsive to the cultural needs of patients and their families;

at the same they must represent the perspective of the culture of medicine. The patient experience with care is shaped by each interaction with a provider of health care. Sometimes the patient's perspective should prevail, sometimes the provider's and sometimes collaboration will result in a new optional outcome (Dreachslin, Gilbert and Malone 2012: 219).

There are a number of negative effects that can be caused by cultural diversity in the health care context. Much of the literature examined so far explains that negative effects are likely to occur because of cultural diversity. Samovar, Porter and McDaniel (2013: 329) concur that the objective of medicine is to deliver suitable and correct health care for all patients, which requires that the health care providers have a strong capability, as well as the skill to understand and work effectively with patients whose beliefs, values and histories differ from their own.

Patient satisfaction is an important indirect measure of quality of care because it directly impacts on the outcome of treatment and therefore holds great value for the clinician (Moore and Bowden-Everson 2012: 12). Entabeni Hospital has committed itself to finding out about customer satisfaction, customer satisfaction being one of their objective. The hospital monitors customer satisfaction through feedback cards, which patients complete at the end of the medial process before being discharged. Unfortunately, these cards cannot be shared with external persons. However, it is good that the hospital is concerned about patients' thoughts and satisfaction.

Life Healthcare (2017) states that

> Life Healthcare has set the objective of delivering a superior patient experience across all touch points, in all facilities and business units. While many aspects contribute to a positive patient experience, we believe that a patient journey is enhanced through thoughtful behaviour from all who interact with that patient. In every interaction Life Healthcare staff are encouraged to be mindful of their behaviour and the impact it may have (positive or negative) on the patient's experience of care.

Furthermore, according to the National Patients' Rights Charter of the HPCSA (2017) "every citizen has the right to participate in the development of health policies, whereas everyone has the right to participate in decision-making on matters affecting one's own health".

Based on the National Health Patients' Rights Charter, patients should play an active role in communication during the medical process. Based on the modern cultural belief, individuals should be self-determining free agents and not passive followers of authority. Patients are consumers of health care in South Africa which has certain ethical and legal implications (Rowe and Moodley 2013: 3).

Passiveness is dependent on the individual's character which can be influenced by their background and social relations. For instance, an individual (patient) who comes from a society where they are taught that a person with a higher rank or status is the dominator who makes all the rules and cannot be argued with, is likely to remain passive during an interaction with a doctor who may be better educated then him or her irrespective of the field – this can result in one-way communication. Notice that the patient in this situation may not be remaining passive because they do not know how to translate the sender's message. It could be out of showing respect for the class or status of the health care professional relating to the patient. Meanwhile, a patient raised in a community where freedom of expression is encouraged and openly practised will freely question and translate the message sent by the health care worker, building a platform of two-way communication. This can be regarded as the effect of new culture: a culture that extends power to the patient. This study aims to analyse how the relationship is affected by the cultural aspects: language, culture and status.

Patients are now the ultimate decision-makers. The new Consumer Protection Act in South Africa applies to consumers and patients alike. It enforces strict liability for harm caused by goods and services. Everyone in the supply chain, including the doctor, can be held jointly and severally liable. This may lead to enormous challenges in health care delivery. Viewing patients as consumers may be detrimental to the doctor-patient relationship (Rowe and Moodley 2013: 5).

2.5.5 The effects of cultural diversity in the health care context

With the focus on language, class and gender, this section identifies how these cultural variables affect communication, within a health care context. Napier *et al.* (2014: 1610) state that as globalisation continues, cultural diversity decreases, denying people not only the benefits of genuine differences, but also the different kinds of knowledge that characterised humanity in former times. Arguably, this statement by Napier *et al.* (2014) can be disregarded in in South Africa and KwaZulu-Natal which keeps being populated by people from different parts of the country, coming to Durban in particular. Durban is populated by students and professionals from different parts of South Africa. These people possess diverse cultural attributes, since they come from different ethnic groups, speaking different languages, having different genders and are from different levels of social classes. At some point, these individuals require medical attention. Those who possess the means will access private health care. Their behaviours will be affected by the cultural backgrounds they are from.

Wellbeing is increasingly recognised as being both biological and social. Therefore, health care providers can only improve outcomes if they accept the need to understand the sociocultural conditions that enable people to be healthy and make themselves healthier, that is, to feel well (Napier *et al.* 2014: 1611). Bearing in mind this understanding, there is a lot to be lost to health care by ignoring the cultural systems of value of not only patients, but also caregivers, health administrators, charities, and researchers (Napier *et al.* 2014: 1611). To achieve such understanding, the role of communication must be in appropriate placement with the diversity in cultural backgrounds as communication assists us in making sense of the world.

According to Cockerham (2013: 126) people may feel obligated to the responsibility of living and strains embedded in class hierarchies can create stressful circumstances which are beyond their control, which thereafter can affect their physical and mental health. This indicates the depth of influence associated with class which allows certain experiences for some and limits others. When an individual is categorised by the background that they originate from and have that projected to their profession, this

can distract the process of making a diagnosis. It can depend on the approach the analysis and conclusion are drawn from, if the results of the diagnoses are positive or negative. Samovar, Porter and McDaniel (2009: 358) concur that if communication between healthcare providers and patients is not clear; the entire medical treatment process is problematic. This hinderance is usually as a consequence of cultural diversity, which includes non-biological variables.

Cockerham (2013: 157) supports the observation that non-biological variables such as race are applied in a discriminatory fashion to less powerful racial subgroups and the disadvantages include reduced opportunities for good health. This is the negative effects of race and class. In a country like South Africa, with a history of racial discrimination (and Durban and KwaZulu-Natal are dominated by Black and Indian people) the statement by Cockerham (2013) is relevant for the occupants there. Moreover, it becomes problematic when these cultural aspects influence and affect decisions within a private health care context.

Studies of South African health system point out how access to and provision of health services are limited by race, class and gender. This is relevant to Entabeni Hospital which renders services and accepts patients from different races, genders and classes for admission. This raises an argument that a person may receive good or bad health care service depending on which cultural background they are from.

Giger and Davidhizar (2008 cited in Dreachslin, Gilbert and Malone (2012: 238) identify the following six cultural phenomena that shape health care encounters in the context of diversity:

1. Communication;
2. Space;
3. Social organisation;
4. Time;
5. Environmental control; and
6. Biological variations

The above six cultural phenomena have been explained in the previous literature. The cultural phenomena identified by Giger and Davidhizar (2008 cited in Dreachslin, Gilbert and Malone 2012: 238) can be aspects of the barriers of culture previously mentioned in the literature, under the section in culture. The reason for this is that individuals may utilise these cultural symbols inappropriately. Dreachslinm, Gilbert and Malone (2012: 224) point out that when cultural barriers in the health care setting negatively affect access and lead to patient dissatisfaction and lack of adherence with prescribed treatment, the result is often poorer health outcomes. With good reason, no hospital can be honestly satisfied with poor outcomes from the treatment process, as this affects the image of their institution as well as their credibility and liability.

According to Samovar, Porter and McDaniel (2011: 338) “providing competent health care to a culturally diverse population demands that clinicians become aware of their own biases, values and ethnocultural background as well as the implicit assumptions of the subculture of western medicine”. It is necessary for health care professionals to be aware and sensitive to how patients relate their cultural beliefs to medicine, in order to provide the best health care that meets the patients’ needs and is not contradictory to their beliefs. Moreover, health care workers need to understand their patients’ point of view, so that the rights of patients are not violated in any manner

2.5.6 Medicine and patients’ beliefs

Values and behaviour are largely socially conditioned; therefore, it is crucial to understand the cultural factors that influence treatment-seeking behaviours and treatment adherence so as to maximise health outcomes Napier et al. (2014: 1615).
Samovar, Porter and McDaniel (2009: 358) affirm that cultural diversity in world views may unfavourably hinder effective communication between patients and health views

Napier *et al.* (2014: 1631) state:

> Intercultural communication in a health care setting is not only focused on language proficiency, but also on the people’s beliefs about their personal levels of competencies on illness prevention and to what institutes effective health care. Although subjective

> complaints, for instance levels of pain, or perceived weakness are often negatively attributed to culture, the same problems that result from emotional stress can be the basis for forming caring and unquestioning ties, when health care workers are aware of the origin of the complaints, and if they have an accurate and effective strategy to address them.

This suggests that when health care professionals deal with patients they should be well informed of the patients' cultural backgrounds. It is can be difficult to learn about patients' culture once they are present within the context. The reason for the challenge may be that, once patients enter into the health care context, health care professionals who have not been exposed to the cultural practises, perhaps one patient engages in, may be anxious to how they can treat the patient in a manner that respects and acknowledges the patient's culture. Thus, health care professionals need to learn the cultures of the people in the region they are operating in. For instance, staff in Entabeni Hospital, operating in Durban, need to be completely informed regarding the cultural background of white, Indian and black people. Although the hospital is governed by certain national medical rules and principles, the patients' norms should be highly respected.

Medicine has its own rules and principles that form medical cultural practices. However, these cultural practices are updated and changed from time to time to meet the current situations and needs of patients. Patients also have their cultural practices that are socially derived. It is crucial to understand the reason why patients visit an environment as the health care sector.

Patients enter hospitals seeking health care services; the pre-conceived beliefs they enter with are bound to have an effect on their reactions to the culture of the new environment. Cockerham (2013: 1) states that social variables may be more powerful in inducing adversity or enrichment in health outcomes than formerly assumed, and that society can make you sick or promote your health. The author adds that most diseases have social connections. Samovar, Porter and McDaniel (2013:338) concurs that the knowledge of patients' culture background is regarded as helpful; however medical consultants are cautioned against the possibility of stereotyping.

2.5.7 Social influence on health

Social factors such as living conditions, lifestyle, norms, social values, and attitudes are not pathogens like germs; but they can initiate the pathology and, in this way serve as a direct cause for a number of diseases (Cockerham 2013: 2). Cockerham (2013: 6) affirms that denying the role of social processes in the onset of health problems stemming from cultural practices renders any explanation incomplete.

Therefore, health professional need to aware of social norms and devise a plan to address them. In a health care context, it is believed that patients require special attention and treatment, therefore the multidisciplinary team, which includes, doctors, nurses, dieticians, social workers and so forth are required to be sensitive to the needs of the patients, taking into consideration their cultural backgrounds to maximise the health outcome.

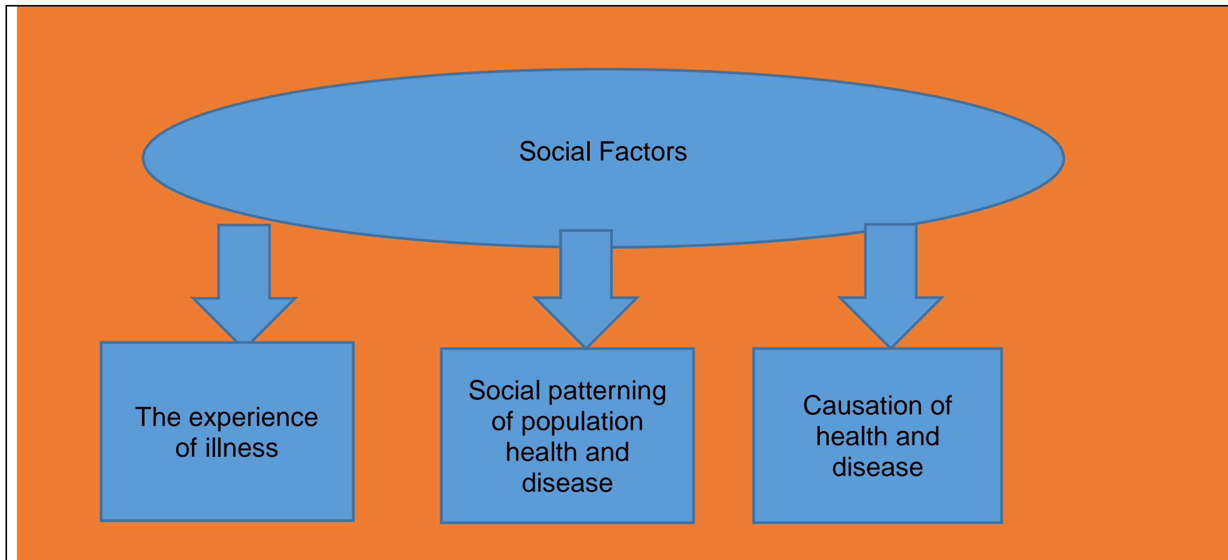

Figure 2.8: Social factors on health and disease
Source: Cockerham (2013: 6)

Figure 2.8 illustrates how sickness emerges from social factors, which may include the environment, social practices, food, and lifestyles, according to each individual's personal experience with illness. This suggests that the way patients view sickness is greatly influenced by the societies they are from. The social patterns as well as the daily rituals which become the residents' norms contribute to sickness. Cockerham (2013: 10) affirms that social factors do not only determine whether a person becomes sick or not but, they also shape the pattern of a population's health and disease, as well as how people experience illness. Furthermore, Cockerham (2013: 10) insists that all societies have social hierarchy and within those hierarchies' health and longevity consistently reflect a gradient in health that is better at the top than at the bottom.

Samovar, Porter and McDaniel (2009: 359) state that theories of health and disease causes are based on prevailing worldviews held by a group. These worldviews include a group's health related attitudes, beliefs, and practices, and are referred to as health belief systems. In the Health and Culture (2014: 1630-1633) identify the following 12 findings that underlie research on health and culture:

1. Medicine should accommodate the cultural reconstruction of wellbeing.
2. Culture should be better defined.
3. Culture should not be neglected in health and healthcare provision.

4. Culture should become central to care practices.
5. Clinical cultures should be reshaped.
6. People who are not healthy should be capacitated within the culture of biomedicine.
7. Agency should be better understood with respect to culture.
8. Training culture should be better understood.
9. Competence should be reconsidered across all cultures: both health professionals and patient's competence.
10. Exported and imported practices and services should be aligned with local cultural meaning: globalisation.
11. Building trust in health care should be prioritised as cultural value.
12. New models of wellbeing and care should be identified and nourished across cultures.

Building trust between healthcare professional and patients should be vital, as relationships are developed through intercultural interactions. The trust between the two parties could minimise any potential miscommunication, which could hinder the success of the journey to effective health care. For instance, a doctor may request a patient to swop with another patient in another room, where the doctor senses it will be more convenient and less of a health hazard, but then the patient will argue that they are being isolated because of the colour of their skin. This then creates a barrier to effective communication, as the patient will tend to interpret the messages disseminated as racially associated, which hinders the original message from being accurately received. Therefore, it is the responsibility of the sender and the recipient to ensure that this type of noise does not affect the message or the communication process.

Lungosi (2013: 5) states that, the creations of identities are linked to the social space. This means that the formation of who an individual identifies and perceives themselves as rests on which social environment they belong to. The clinical encounter is shaped by differences between the health care professional and patient based on social position and power, which are associated with variances in cultural identity, language, and other cultural aspects (Kirmayer 2012: 149).

2.5.8 Culture shock in health care

Communication scholars have explained cultural shock as being the result of expectations not being met. According to Reider (2016: 16) expectations are a result of the subjective collection of the perceiver's accumulated life knowledge and previous experiences. In cases where the expectations are not met, especially in a context of health care, cultural shock exists.

Patients seek love, comfort and hope, through human relationships or various spiritual spheres when confronted with anxiety and helplessness experienced as a result of illness (O'Brien 2011: 2). This is a contributor to cultural shock. Patients may be ill-at-ease when coming into an unfamiliar environment. Irregular practices may contribute to determining if the communication process is effective or ineffective. It is understandable that when an individual is brought into a place where their comfort zone is shaken, and which they are unfamiliar with, that they can feel helpless and suffer from anxiety. Anxiety is simply defined as a state of uneasiness, apprehension about future uncertainties (Folk and Folk 2017: 1).

Anxiety can cause panic – in any situation where an individual finds themselves at unease, panic can be a common response. There can be reactions associated with panic, for instance acting out of context – this may be a barrier to communication in a health care context. If one panics, one is likely to act in a negative way towards the other party – in most instances one tends to be defensive. In the health care context, it can be natural for people to defend their own culture if the medical process contradicts their cultural beliefs and practices. Previous research has indicated that men in certain religions tend to be reluctant to receiving medical assistance from females in cases where need to expose parts of themselves which their cultures forbids expose to women. Some patients may prefer to be assisted by professionals who speak a similar language to them, so that they are able to completely comprehend.

Cultural shock in the health care context is a reason why intercultural communication is essential. Intercultural communication is a fundamental part of modern societies that

affects people from all over the world. Cultural intermixing as a result of migration is an inevitable reality for many countries so needs to be addressed and cannot be ignored (Neuliep 2009: 51).

In order for effective communication to occur in the health care context, doctors, nurses and the entire staff need to recognise this attribute, so that the role of the patient in the communication process can be acknowledged. This requires cultural competence.

2.5.9 Cultural competence in health care

In recent years, cultural competence has become a popular term for a variety of strategies to address the challenge of cultural diversity in mental health services (Kirmayer 2012: 149). It is vital to understand that, in the context of this study, the focus is not only on mental health, but on the relationship between health care professionals and patients generally, which is greatly influenced by the level of communication between the two parties. The communication level is also influenced by cultural factors which in the context of health care impact psychological, spiritual and mental health. Thus, cultural competence is vital for practice, for the benefit of cultural diversity that exists. Furthermore, culture influences the experience, expression, course and outcome of mental health problems, help-seeking and the response to health promotion, prevention or treatment interventions (Kirmayer 2012: 149). Therefore, cultural competence is essential to achieve positive outcomes from the medical process any interaction related to it.

According to Sue *et al* (2009: 154) cultural competence is increasingly being recognised as an essential skill set for health professionals, especially those working in multicultural milieus and with ethnocultural subgroups. Culture is part of every living individual, although not everyone is aware of this. Culture is the attributes that each individual possesses which they relay in interactions with others. Although these may come in different forms, such as language, gender, race or status, they are all cultural attributes. Thus, culture cannot be ignored, or be isolated only to patients with mental illnesses. If a patient is sick, perhaps experiencing intense fever symptoms, the

feelings associated with the experience of the illness can affect their thoughts: cultural competence is required from the health worker to try and figure out or find the root cause, to understand the feelings attached to the illness and to find out what the patient believes can heal them, what they are used to, practices they use to heal themselves.

Because culture provides the concepts through which individuals and communities interpret the world and construct their hierarchies of goals and values, cultural processes remain central to the ethics and pragmatics of health promotion and health delivery (Sue *et al.* 2009: 155). More research is required to identify the competence of health professionals in all spheres within the health care context.

2.5.10 Conclusion

Based on the above literature, it is evident that cultural differences have a major impact on the daily interactions among diverse individuals from different cultural groups. Literature on the effects of culture on communication in a healthcare context has been examined. The next chapter will discuss the methodology for the study.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

The previous chapter provided a theoretical framework for the study. It explained the background and the role of intercultural communication in different contexts contributing to the formation of different cultural norms. The literature identified how culture affects communication in a health care context and emphasised the need for intercultural communication.

Based on the discussions in the literature review, core themes emerged. The data gathered in the qualitative analysis was evaluated and interpreted based on these themes. This chapter outline the research methodology employed for the study, which focused on a particular case study. It elucidates the research approach for the study through the identification of the steps undertaken to acquire information for the research study.

3.2 Research design

Leedy and Omrod (2014: 79) maintain that through data, research seeks to discover the truths that the mind desires to understand. Data is collected once there is research design, which determines how the research is to unfold.

Research design guides the entire process of research and assists the researcher to gain a clear direction for the study. Welman, Kruger and Mitchell (2005: 52) state that research design describes what the researcher will be doing with the participants and the data so as to understand the research problem and make conclusions and recommendations.

Sekaren and Bougie (2013: 95) affirm that a research design is an outline for the collection, measurement, and analysis of data while Welman, Kruger and Mitchell (2005: 52) concur that a research design is "the plan according to which we obtain

research participants and collect information from them". Therefore, it is imperative that the questions for the study be aligned to the objectives of the study, in order to have a research design that conveys informative and constructive knowledge.

This study focused on a single case study and for its purpose an interview schedule guided by a semi-structured questionnaire was employed. The interview schedule comprised questions that aimed to address and elicit responses that related to the objectives of the study. Interviews were conducted with key participants that the researcher assumed would provide comprehensive insights and information relevant to the study. McQuerrey (2017) states that interviews are conducted to provide a platform for follow-up questions so as to be able to obtain detailed answers. The questionnaire which served as the foundation for the interviews in this study was designed to address the points mentioned by McQuerrey (2017).

A qualitative approach was employed since the study aimed to obtain primary feedback from the respondents as clarified through emotion and detailed explanations. An investigation and identification of the existing relationships between healthcare professionals and patients was employed, while studying the significance of promoting intercultural competence and identifying the possible consequences related to intercultural communication within the health care context. The qualitative nature of this study determined the research design for the study.

The research approach selected for the study is a case study focused on a single hospital, and only the staff of Entabeni Hospital participated in the study. Entabeni Hospital is a private hospital that falls under the Life Healthcare group. The hospital is in Durban, KwaZulu-Natal. It caters for all races and genders, from all ages. Sekaren and Bougie (2013:103) explain that case studies focus on collecting information about a specific object and that the idea behind it is to obtain a clear picture of a problem one must examine, which can be a real-life situation from various angles and perspectives using multiple methods of data collection. Seeing that this study adopted an investigative approach, it was appropriate that a case study approach be adopted.

3.3 Target population

Welman, Kruger and Mitchell (2005:52) affirm that the population of a study refers to the study object and consists of individuals, groups, organisations, human products and the conditions to which they are exposed. This study selected a specific health care centre as the organisation and a certain number of the staff from there to be respondents who were also believed to be able to represent the patients.

The researcher believed that the Entabeni Hospital unit managers were suitably exposed to events that occur within the health care context, which relate to the study. Sekaren and Bougie (2013:240) concur that a population is the entire group of people and events that the researcher desires to investigate. According to Leedy and Omrod (2010: 211) the size of a population often makes it impossible to study the whole population. Hence, the need for a sample. For this study the targeted sample was ten unit managers from Entabeni Hospital based in Durban, KwaZulu-Natal. The health care providers selected as the sample, were chosen as they were perceived to have the ability to address the research problem.

Gqamane (2010: 50) stipulates that a research problem relates to a specific population. A target population is an estimated number of the population that a researcher intends to use for the study which the researcher believes will be able to provide valuable and informative feedback that will address the research problem. As previously mentioned, the target population for this study were the unit managers of Entabeni Hospital who interact with patients on a regular basis, who were conveniently placed to observe both professionals and patients. Therefore, the researcher assumed that the sample had the ability to convey the views and perceptions of the relationship between the hospital's health care professionals and patients. Thereafter, the events that occur between patients and health care workers of Entabeni Hospital were described based on those views. It is the views described by the sample that aimed to address and provide explanations to answer the research problem.

Unit managers engage with patients to investigate patient satisfaction or dissatisfaction with regards to the services rendered by the hospital, specifically the

relationships between the multidisciplinary team of doctors, nurses and other hospital staff. The researcher assumed that the unit managers were in a position to provide valuable information on how culture affects communication and interactions in a hospital environment, specifically between health care workers and patients. With this information, the research aimed to identify the intrinsic relationship between communication and culture within a multicultural health care context and how it affects the relationship between health care workers and patients. However, an appropriate sampling method had to be employed.

3.4 Sampling method

Leedy and Ormrod (2005: 144) assert that the particular entities selected by researchers comprise their sample, and the process of selecting these entities is called sampling. Sekaren and Bougie (2013: 240) add that sampling is a process of selecting the right individuals or objects as representatives for the entire population. Sampling assists the researcher in obtaining accurate information, while minimising the possibility of acquiring unsolicited or redundant information. The researcher must ensure that the most appropriate sample is selected. The respondents selected, should be able to effectively and accurately represent the targeted population, hence the unit managers were selected from among the entire staff of Entabeni Hospital.

Sekaren and Bougie (2013: 245) identify the two major types of sampling: probability and nonprobability. In probability sampling, it can be predicted that each segment of the population will be represented, while in nonprobability sampling, it cannot be guaranteed that each element of the population will be represented (Leedy and Omrod 2009: 205-211). Sekaren and Bougie (2013: 245) add that in nonprobability sampling, the elements do not have a predetermined chance of being selected as subjects.

For the purpose of the study, nonprobability purposive sampling was employed. The rationale for employing purposive sampling was to ensure that by focusing on specific characteristics of the population selected, the research would be able to meet the objectives of the study. The ten respondents were made up of one manager from each unit representing the patients and the staff of that unit. The staff comprised nurses and

doctors from ten different units within the hospital. Social status, gender and race representation at the Entabeni Hospital were also criteria that the researcher used to select the respondents. Therefore, the differences in the cultural variables that exist within the Entabeni Hospital were intended to be represented as the nature of the study required**.**

Welman, Kruger and Mitchell (2005: 69) explain that the most important type of sampling is purposive sampling for nonprobability sampling. In this method the researchers rely on their knowledge, ingenuity and experience to achieve an assessment that will represent the relative population. This sampling method allows for symbolic representation in the study. It is assumed that the selected sample may not represent the entire process of intercultural communication that transpired between every patient and every staff member at the hospital.

As highlighted by Sekaren and Bougie (2013: 252), the findings of nonprobability sampling cannot be generalised, because type of sampling does not represent the entire segmentation. Nevertheless, this type of sampling is relevant in protecting and avoiding the inconvenience of some elements of the population, specifically in a health care context where patients may not be permitted to participate in the study as a result of ethical criteria. Hence the selection was made based on the cultural diversity within the hospital and the patients who receive healthcare service from the hospital.

3.5 The sample

Patients could not participate as respondents, due to consideration of their vulnerability, which is the reason why they were represented indirectly by the unit managers. Members of the hospital’s multidisciplinary team which includes nurses and doctors could not be selected as participants, because of their hectic working hours and schedules. Thus, the unit managers were selected to represent both the health care providers and patients, as the managers directly interact with both parties at all levels.

The ten unit managers were the only participants who engaged in the study. The responses from the participants were obtained only through the measuring instrument that was selected and designed by the researcher, in considering the nature of the study.

3.6 Measuring instrument

Leedy and Omrod (2014: 83) state that measurement instruments provide the foundation on which the entire research effort rests. The measurement instruments included questionnaires and interviews which were used to collect data from research respondents. These were appropriate measuring instruments considering the type of available data. The study employed a face-to-face interviews approach which was navigated by means of a semi-structured questionnaire. The usage of the measuring instruments will be further explained on the next sections of the chapter.

Leedy and Omrod (2014: 83) state that measurement limits the data of any phenomenon whether substantial or insubstantial, so that those data may be interpreted and compared to either qualitative or quantitative standards. This is also dependent on the objective of the study, conducted.

The objective of the study was to identify the qualitative phenomenon that describe the intercultural relationships that may exist between the hospital staff and the patients, and to identify the role of intercultural communications within the health care context. The aim was to understand how cultural diversity affects and contributes to communication within a health care context. Bearing this in mind, the study required the following measuring instrument to obtain authentic results: questionnaires and interviews. Questionnaires were intended to be used as the primary source of information and feedback from the research respondents; hence the questionnaire was lengthy providing both open and closed ended questions. Interviews were selected as a follow up to discuss in detail certain open ended questions thereby obtaining in-depth information.

3.7 Data collection

Leedy and Omrod (2014: 99) state that data are collected from large samples that represent the population in forms that are easily converted to numbers. This type of representation of data is more valuable in a quantitative approach. The responses by the selected sample from this study, which was obtained from questionnaires and interviews, was converted into numbers. This brought about the quantitative approach, which was the only part where the approach was used in the entire study. This was done so that the information obtained can be easily translated and comprehended. The translation depended on the type of data collected.

There are two types of data: primary and secondary data. Sekaren and Bougie (2013: 113) explain that primary data consists of information obtained first-hand by the researcher on the variables of interest for the specific purpose while secondary data is gathered from sources that already exist. For the study, the researcher focused on acquiring primary data from the research participants, which was the selected staff of Entabeni Hospital, through interviews and a semi-structured questionnaire, which will be discussed on the next section. The researcher also intended to acquire primary data from the nurses, doctors and patients, but due to the hospital's policy and research ethics patients had to be excluded. Thus, the unit managers represented both patients and the multidisciplinary team.

The secondary data was acquired for the literature review through books, journals, articles, and online materials. Secondary data could have been obtained from the Entabeni Hospital's archives, and records, such as feedback cards that measure patients' satisfaction. However, the hospital's policy does not allow this. Therefore, the researcher had to rely on the other materials for secondary data and to questionnaires and interviews for primary data. Bearing in mind that most of the respondents were not available to complete the questionnaire, interviews were conducted with the remaining respondents when they were available.

3.7.1 The questionnaire

It was stipulated in the questionnaire that participation was voluntary. A note at the beginning of the questionnaire assured the respondents of confidentiality and informed them of the fact that the findings obtained would be used to enhance intercultural competence between patients and health care providers within the hospital. Thereafter, explanations were provided for the three sections of the questionnaire of which the first section requested consent from the respondent before they completed the questionnaire.

The sections were divided as follows:

- Section A requested consent of the respondent to complete the questionnaire.
- Section B sought the respondents' understanding of intercultural communication and its influences on the relationship of health care workers and patients.
- Section C asked the respondents to identify the consequences of intercultural communication and their understanding of cultural shock.

The questionnaire consisted of 17 questions in total with open-ended and closed-ended questions. The closed-ended questions served to provide statistical descriptions. The open-ended questions aimed to get explanations from answers to the closed ended questions. The open-ended questions aimed to allow the respondents to openly express themselves and provide informed responses. The questions were structured in such a way that the respondents were able to elaborate and explain their experiences and responses.

Although the questionnaire had followed up questions, interviews were required to allow interaction between the researcher and the respondents. Additionally, the interviews allowed the researcher to receive the primary emotion and feelings related to each question's response and allowed the respondents to ask for more clarity on certain questions that were not well understood. The interviews allowed the researcher the opportunity to obtain detailed information through follow-up questions and enabled the interviews to thoroughly address the key objectives.

Moreover, the decision to use both questionnaire and interview questions was made based on the relevant literature which indicated that the type of research being undertaken required substantial information.

3.7.2 Interviews

The researcher organised interviews with selected unit managers instead of the multidisciplinary team (nurses and doctors). The interview questions were based on the semi-structured questionnaire, since the questionnaire was not completed by most of the research participants. The interviews took place at Entabeni hospital and were undertaken by the researcher. The interviews were arranged at the convenience of the participants. The selected research participants suggested to the researcher that interviews be conducted ins their personal offices. Thus, the researcher went to each manager's office for the interviews.

When the researcher arrived at the respondent's office, she formally greeted the unit manager. After the formal greetings, the interviewer informed the manager about what the study entailed. Thereafter, following agreement by the manager that they understood the nature of the study, and consented to participate in the study, the interview commenced. To ensure a full record of the participants' responses to the questions from the interviews, the interviewer used a notebook, mobile cell phone and a tape recorder.

Gqamane (2010: 53) concurs that to obtain any type of data for research, a researcher should record any potentially useful data thoroughly, accurately and systematically, using field notes, audiotapes or any other suitable means. This helps keep records and evidence of the data, so that when the information needs to be analysed, the data is available, and the researcher can refer to it.

In the early interviews the researcher used her cell phone to record the research participants' responses, while taking notes of key points mentioned by the respondent during the interview. However, for the later interviews a digital voice recorder was utilised.

3.8 Data Analysis

Leedy and Omrod (2014: 99) assert that data analysis is subjective in nature; the body of the data is scrutinised in search of patterns. The data collected is translated and thoroughly examined to search for any gaps.

The data analysis stage assists in making sense of the data, clarifying all factors involved, providing particular explanations. To do such analysis, data received from the administered questionnaires and interviews were translated into graphs and charts, to thoroughly scrutinise and identify any gaps. Since this study was qualitative in nature, the data obtained through interviews and the questionnaire was translated into Microsoft office Excel and Word to provide a clear understanding and interpretation of the responses by the participants.

The analysis was done so that the data collected could be read and comprehended by other people interested in the study. The primary data gathered from the interviews and also from the questionnaires was analysed and used to offer recommendations for the study and to make conclusions based on the findings.

3.8.1 NVivo and SPSS

NVivo is software that assists in analysing and organising unstructured data. This enables researchers of qualitative studies to arrange information in such a way that they can examine relationships in the data, while testing theories and identifying trends (NVivo 11 September 2015). NVivo was used to analyse the qualitative data obtained from the interviews. This was necessary to accurately analyse the data.

SPSS was also used to analyse the data. Bronstad and Hemmesch (2010: 2) explain that SPSS is used in many fields such as market research, psychology, business, government and sociology. This software was used to manage and accommodate the volume of data obtained during the course of this study. Although in the next chapter, the findings are largely presented in quantitative form, SPSS was used to largely

analyse the feelings attached to the responses as well as the psychology behind the responses.

3.9 Pilot Study

A pilot study is the pre-test of a study, where the researcher selects two or more but not more than five participants to try out the feasibility of a study by administering questionnaires to them to check its relevance. Leedy and Omrod (2014: 114) confirm that “a brief pilot study is an excellent way to determine the feasibility of the study”. This type of study is important for the researcher because it assists the researcher to easily determine if the study is relevant or not. It pre-tests the measurement of the instrument. It is a stage that enables the researcher to change or add necessary information for the effectiveness of the study. It tells the researcher which information is needed, and which is not, what to add or omit.

Three respondents were selected for the pilot study: the human resource manager, public relations and communications’ director and one representative from the client services department. The pilot participants were selected based on their knowledge of the communication between the health care providers and patients of the Entabeni hospital.

3.10 Case study

The study focused on a case study of Entabeni Hospital, Durban, KwaZulu-Natal. The hospital is a private hospital, which renders services to patients of all races, genders, ages and classes. This is the only hospital that the study focused on. It was chosen based on its high calibre, and work ethic. The researcher identified this hospital and chose it mainly because it a private hospital since most similar studies have been based on public health sector hospitals.

Life Entabeni Hospital is a member of Life Health care, one of the largest private hospital groups in South Africa, operating 63 acute care facilities across the country. They believe delivery of the world class healthcare is achieved through a combination

of unparalleled quality and clinical excellence along with a true focus on personal needs of their families (Life Entabeni Hospital 2016).

3.10.1 Limitations of the research approach

The following were the limitations of the study:

- A cell phone was also used as the recording tool.
- Arranging interviews and obtaining feedback from the participants was a challenge because of their busy schedule.
- The Entabeni Hospital's website has only limited information. For this reason, the researcher was required to rely on information received through primary data.

3.11 Validity and reliability

According to Sekaren and Bougie (2013: 225) validity is "a test of how well an instrument that is developed measures the particular concept it is intended to measure". Validity measures the strength and the appropriateness of a tool that needs to be tested. The relevance and significance of the study is determined in the process.

Sekaren and Bougie (2013: 225) further explain that validity is concerned with whether we measure the right concept, while reliability is concerned with stability and consistency of measurement. Based on this, a questionnaire that interlinks to the objectives of the study was used as a measuring tool. Validity was tested during the pilot study and any gaps identified were rectified before the implementation of the main study.

It is imperative that validity is determined for every study, so that the researcher can identify what is significant or not and make accurate recommendations. Sekaren and Bougie (2013: 226-227) identify three types of validity:

1. Content validity ensures that the tool measures an adequate and representative set of items that tap the concept.

2. Criterion-related validity is established when the scale discriminates individuals who are known to be different.
3. Construct validity testifies to how well the results obtained from the use of the tool reflect the theories around which the test is designe

This study addressed all the types of validity identified by Bougie (2013). The three types of validity identified also contributed to the extent of the investigation, for this study. The content validity was determined by the research tool: questionnaire and interviews. While the criterion was the selection of the sample that participated in the study as respondents and construct was the data analysis tools used in this study.

Leedy and Omrod (2014: 91) assert that the extent to which a researcher can learn something about the phenomenon under investigation relies on the validity and reliability of measurement instruments. Reliability and validity testing of an instrument used to collect information for a study can assist the researcher in knowing which information to add or exclude.

Sekaren and Bougie (2013: 225) affirm that reliability is a test of the consistency of a measuring instrument. The researcher uses reliability to ensure the credibility of the information provided by participants. To ensure reliability each section in the semi-structured questionnaire was explained by the interviewer to alleviate misunderstandings, and responses to the questions were compared. Credibility is related to consistency in the responses by the participants. Where the researcher noticed and observed that the participants consistently provided similar responses to certain questions, these were regarded as credible.

3.12 Triangulation

Leedy and Omrod (2014: 104) explain that triangulation is multiple sources of data that are collected with the hope that they will congregate to support a theory. It is common in mixed method designs. Triangulation had been employed in this study by combining the information obtained from the participants both from interviews and questionnaires, to support the theory of the study.

3.13 Conclusion

This chapter has discussed the research design and the steps taken by the researcher to collect data for the study, it has explained the steps to be adhered to ensure the appropriate conduct of the study. The next chapter will present and discuss the data that was obtained.

CHAPTER 4: DATA ANALYSIS

4.1 Introduction

The previous chapter provided an explanation of the steps taken by the researcher to obtain the data for the study. It described the methods undertaken in conducting the study, and thoroughly explained the research methods in relation to the type of the study, which is qualitative. This chapter presents the results and discusses the findings obtained from the questionnaires distributed and interviews conducted for this study. This chapter illustrates the statements of findings, interpretation and discussion of the primary data.

The questionnaire was the primary tool used to collect data, it was distributed to health care workers at the Entabeni Hospital, Durban, KwaZulu-Natal. The data collected from the responses were analysed using Nvivo and SPSS version 24.0. The results are presented in the form of graphs, cross tabulations and other figures for the quantitative data that was collected. Inferential techniques include the use of correlations and chi square test values, these are interpreted using the p-values. The analysis includes discussion of how the data obtained concurs and relates to the literature for this study.

4.2 The sample

In total, 10 questionnaires were dispatched and two were returned, which gave the 20 % response rate. Therefore, the researcher opted to conduct interviews instead, with those participants whom preferred interviews rather than questionnaires. Time required to respond to the questionnaire presented as a challenge for the respondents. Therefore, interviews were the best option as they allowed respondents to participate in the study depending on their availability. The interviews were conducted with 10 respondents who were unit managers, from the ten units at the Entabeni Hospital.

The researcher aimed to include all races, classes and genders within the hospital. However, challenges resulted in exclusion of some of the multidisciplinary team (nurses and doctors). Therefore, it was appropriate that only the unit managers participate in the study. Thus, only the races, gender and classes that existed within the sample were involved in this study. The race range included one black male, one black female, one female Indian, three white females, and four coloured female unit managers.

4.3 The research instruments

The research instrument consisted of 18 items, with a level of measurement at a nominal or an ordinal level. The questionnaire was divided into 3 sections which measured the themes and topic illustrated below:

1. Request for permission to use the participants' response for the research.
2. Intercultural communication.
3. Cultural shock.

4.3.1 SECTION A – Consent and confidentiality

This section was for the respondent to confirm their consent to participate in the study, as respondents. It was to assure them of their confidentiality, that their personal information will not be disclosed. In addition, the section explained that the study forms part of academic research.

4.3.2 SECTION B – Intercultural communication

This section provided an understanding of what intercultural communication is, according to the Entabeni Hospital health professionals.

4.3.2.1 Understanding of intercultural communication

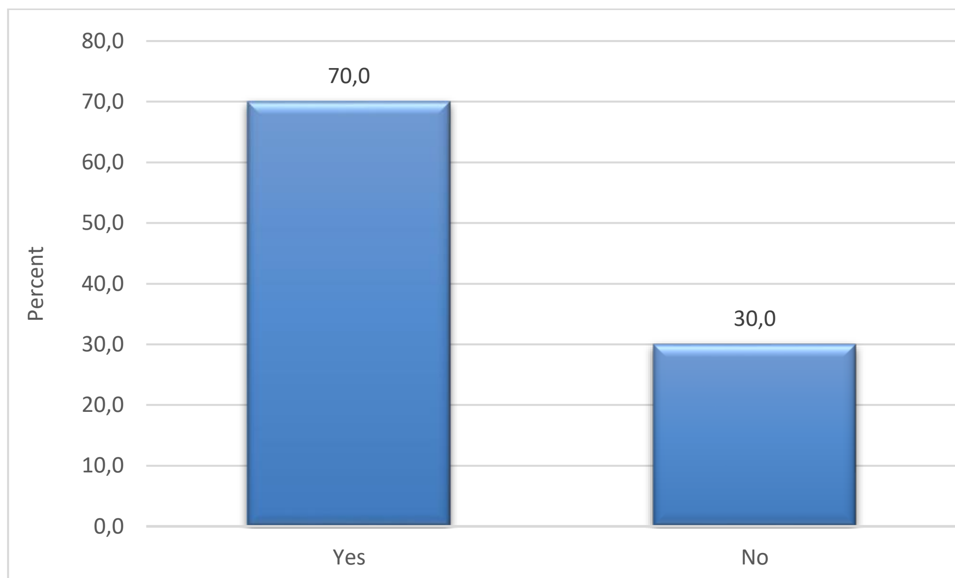

Figure 4.1: the number of respondents that understand intercultural communication

The majority (70 %) of the respondents indicated that they understand what intercultural communication means. However, 30 % of the remaining respondents indicated that they had no knowledge of what intercultural communication was. The traditional approach to reporting a result requires a statement of statistical significance. A significant result is indicated with “$p < 0.05$”. The chi square p-value indicates that the scoring pattern is not that different (chi square $p = 0.206$), which could be due to the sample size in this study. The high percentage provides a likelihood that intercultural communication exists within Entabeni Hospital.

The 70 % represented above provided the following interpretations of the term intercultural communication:

- Sharing of information across cultures using communication methods.
- Communication between different cultures, taking into consideration the different cultural variables.
- Appreciating and recognising other people’s cultural variables when communicating.
- Allowing communication between people from diverse cultures.

The definitions above are very similar. The definitions provided by respondents can be summarised as saying that intercultural communication is a type of communication which allows individuals from diverse cultural backgrounds to share information through different communication methods, while the people involved in the communication process are culturally sensitive. Samovar, Porter and McDaniel (2010: 12) concur and explain that intercultural communication is a type of communication that involves interaction between people whose cultural perceptions and symbol systems are distinct enough to alter the communication event. It can be concluded that the majority of the sample are aware of intercultural communication, based on the data obtained.

4.3.2.2 Intercultural communication within Entabeni Hospital

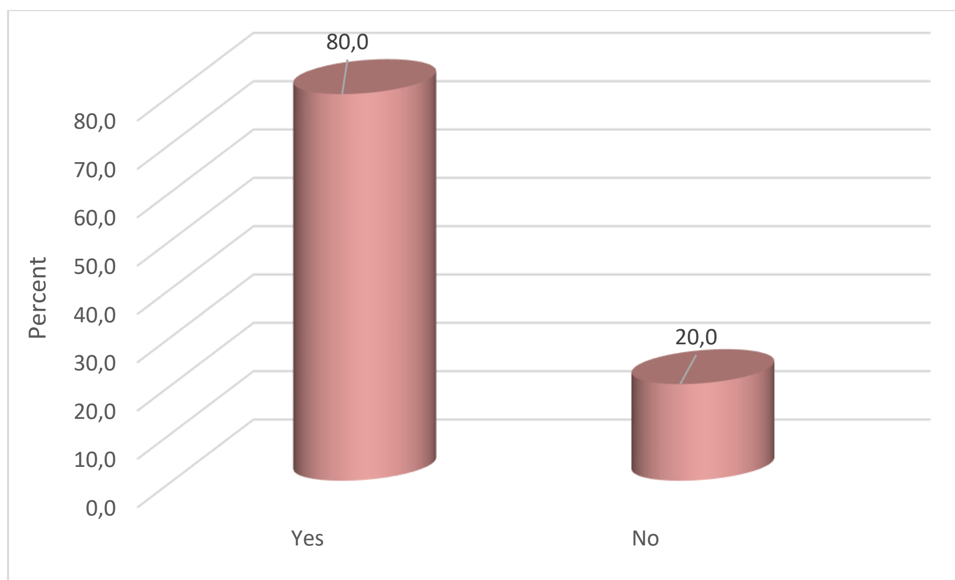

Figure 4.2: The existence of intercultural communication at Entabeni Hospital

Hofstede, Hofstede and Minkov (2010: 202) explain that in medicine cultural traditions are formed to avoid uncertainty. The cultural traditions that are formed in medicine consist of policies, and terms of conditions, which are established to guide both the patient and the health care practitioner's conduct within the health care setting. Cultural traditions interlink with social norms. The interrelation thus gives way for intercultural communication's existence within a health care context. The majority of respondents (80.0 %) believed that intercultural communication exists within the

Entabeni Hospital (p = 0.058) while 20 % indicated that they do not think that intercultural communication exists within the hospital. The results indicate that intercultural communication does exist within Entabeni Hospital; it can be concluded that the respondents recognise and are sensitive to cultural diversity within the hospital. In addition, it appears that the hospital allows communication to take place, recognising the cultural differences. These are justified by the statistics described in Figure 4.2.

Unit Manager 1 stated that “Entabeni Hospital acknowledges itself as the multicultural environment, that looks into providing health care to patients while accommodating their cultural needs”

Therefore, it is important that based on the above responses, explanations of the different scenarios experienced that indicate that intercultural communication exists within the Hospital are described to back up the evidence of Figure 4.2. The scenarios are presented in Table 4.1, as expressed by the respondents.

Table 4.1: Different scenarios of intercultural communication at Entabeni Hospital

	Frequency	Percent
It automatically exists as cultural diversity exists among the health practitioners and patients	1	10.0
It is important and exists in the sense that unit managers in the hospital need to know a patient’s culture in order to assist them	1	10.0
The hospital deals with people from different cultural backgrounds daily, which makes it impossible for intercultural communication not to exist	3	30.0
The hospital has a rich cultural diversity, which interact through communication for the team to function they need to communicate	1	10.0
The hospital is aware of cultural diversity; more work is required to teach and model cultural sensitivity to student nurses	1	10.0
The hospital is aware of the cultural diversity that exists among the patients also with the staff; few complaints are received from patients as patients have a common understanding with the staff and understand the cultural background of the staff	1	10.0

Table 4.1 shows the frequency of the number of people that showed similar thoughts and feelings towards different scenarios, relating to intercultural communication, within the Entabeni Hospital. From Table 4.1, three respondents (30 %) confirmed that the hospital deals with patients from diverse cultural backgrounds, which according to the respondents, means intercultural communication exists within the hospital. “The

hospital understands the cultural diversity amongst the patients and acknowledges the differences by ensuring that the health care professionals from the hospital are aware of this and work in providing effective communication, which recognises of the different cultural backgrounds the patients come from" stated Unit Manager 2.

This justifies Samovar, Porter and McDaniel's (2010:12) confirmation that intercultural communication is a type of communication that involves interaction between people whose cultural perceptions and symbol systems are distinct enough to alter the communication event.

4.3.2.3 The communication component in the hospital

Table 4.2: Respondents who indicated communication as an important component in the hospital

	Frequency	Percent
Yes	10	100.0

Table 4.2 shows that 100 % of the respondents indicated that communication is an important component in the hospital. The percentage indicates that communication is vital for all operations within the health care context. The respondents further explained that communication allows both the patients and the staff of the Entabeni Hospital to share messages that are essential for the survival of patients, which is an advantage for the staff that work directly with patients. Moreover, communication plays the main role in the interaction of patients, nurses and doctors.

In relation to Question 3, Table 4.3 provides explanations for the above results.

Table 4.3: Descriptions of the role of communication in the hospital

	Frequency	Percent
It allows the for an effective passing of the messages	2	20.0
It allows the for an effective passing of the messages even the cultural symbols	1	10.0
It has an influence and affects the care of a patient; it builds rapport for the patients to understand and clarity on everything concerning the health care process; it provides a platform for health education	1	10.0
It helps consider every other component of culture	1	10.0
It is vital to pass messages to patients; creating awareness	1	10.0

It is vital to pass messages to patients; creating awareness on all medical related cases/procedures	1	10.0
It's vital; the hospital sends and emphasises on communication, however there are challenges in the dissemination of information to communicate with the staff	1	10.0
To allow understanding of messages that are intended to be passed between the staff and patients	1	10.0
Without communication, info does not spread properly	1	10.0

Resulting from these, there could be negative consequences that may hinder the important role of communication. This study specifically focuses on the communication between heath care professionals and patients. Griffin (2009: 6) concurs that the process of communication requires an interaction which can be in a form of action, where messages are created to be shared. Therefore, the aim is to identify the role of intercultural communication in the context, looking at the aspects that can impact and affect the communication process. These aspects are presented below.

4.3.2.4 Causes for poor communication between health care practitioners and patients from diverse cultural backgrounds

Table 4.4: Communication barriers

	Frequency	Percent
Attitude; Language; not listening; misunderstanding	1	10.0
Language	2	20.0
Language barrier	1	10.0
Language barrier; educational gap between the patient and health care worker	1	10.0
Language barriers; ignorance of other cultures	1	10.0
Language barriers; ignorance of other cultures; personality traits; hierarchy	1	10.0
Language; unwillingness to accommodate both parties' needs; incorporation	1	10.0
N/A	1	10.0
Patients always wanting to directly speak to the doctor; cultural shock	1	10.0
Total	10	100.0

The responses in Table 4.4 clearly indicate that language is the main communication barrier. To clarify this further the researcher requested examples of scenarios which had occurred and caused frustrations for both patients and health care professionals during interactions within the health care context.

Unit Manger 3 explained that “there is a minority of African black people admitted to the hospital whom mostly communicate in IsiZulu. Consequently, patients of different races constantly have a sense of being racially undermined, where in most cases patients associate certain instructions from health professionals as racial discrimination. This could be in language spoken to a patient and this will be compared to how a different race group is addressed, this is specifically with African black people, whom constantly would associate every instruction to the colour of their skin and often feel that their native language is undermined”

Ntuli (2012: 20) states that during our interactions we usually encounter people with different languages who come from diverse cultural backgrounds different from our own. Taking into consideration what Ntuli (2012) states, there is a great like hood that we as individuals become frustrated as a result. The researcher was prompted to ask the participants to explain any frustration which they may have been encountered between patients and health professionals within the hospital. Unit Manger 3 further elucidated that the constant stereotyping of patients and the lack of knowledge in addressing intercultural communication between patients and health care professionals presented barrier between successful intercultural interactions. Thus, leading to a breakdown in communication. As a result, the entire medical process becomes compromised.

Samovar *et al* (2009: 358) affirm that where communication is not clear between patients and health care providers the whole medical process becomes problematic. It is for this reason that frustrations may arise from both sides: patients and the staff from the health care centre.

4.3.2.5 Frustrations encountered between health professionals and patients

The respondents indicated that language was the main communication barrier, which caused frustrations during between interactions between health care professionals and patients. The communication barrier resulted in misunderstandings. Respondents explained that this barrier meant that in certain situations patients could not express

themselves as they wanted to, and situations where a health care worker could not understand the language spoken by the patient and vice versa. An example from respondent was that a Chinese speaking patient could not understand what a nurse was communicating in English, excluding the medical jargon. There was misunderstanding because of the different languages; an interpreter was not available to assist with translation, which created panic on both sides, which led to the parties being frustrated. Witte and Morrison quoted in Samovar, Porter and McDaniel (2009: 478) assert that for individuals coming from different cultural backgrounds it can at times be a challenge to verbally express their feelings and symptoms in a nonnative language.

It is normal that in a situation where an individual does not know how to respond frustrations develop. One other cause of frustration was dealing with the emotions of patients who are affected by their medical problem. An example shared by a respondent was where a health care professional had to assist a patient experiencing an emotional crisis. The patient had a personal crisis caused by their health issues. The professional had difficulty trying to deal with the situation, having to learn to be empathetic.

4.4.5.1 Resolutions to the Frustrations

Table 4.5: Measure taken to resolve the frustrations

	Frequency	Percent
Ensured that there's always nurses who can speak English and isiZulu on the floor	1	10.0
Explained to the patients why certain practices cannot be implemented and why certain procedures are followed	1	10.0
N/A	1	10.0
Teaching the staff how to be sensitive and respectful towards the special needs of a patient; proper allocation of staff; taking everything into consideration; implementing the continuous development programme	1	10.0
Use an interpreter	1	10.0
Used an interpreter	2	20.0
Used an interpreter;	1	10.0
Using the nurses which speak the language of the patient	1	10.0

Using the staff nurses who understand that specific language of a patient	1	10.0
Total	10	100.0

Table 4.5 provides an interpretation of the responses of how the frustrations experienced during interactions between health care profession and patients were dealt with. The unit managers indicated that they are responsible to take the measures explained in Table 4.5. It is the unit manager for each unit who arranges for there to be an interpreter for an event where a patient speaks a different language from that of a health care professional. In a situation where English is not well understood and articulated by both parties, an interpreter was used. This measure has been useful so far within Entabeni Hospital. However, there is still a need for improvement, as the language barrier is still a prevalent obstacle. Valero-Garcés (2014: 14) confirms that the language barrier is a factor that must be considered, because the inability to communicate can lead to health-related complications.

4.3.2.6 Tools that can enhance communication between health care workers and patients from diverse cultural backgrounds

Table 4.6: The role of cultural competence at Entabeni Hospital

	Frequency	Percent
Developing cultural diversity programmes and training	1	10.0
Accommodating the patient by speaking their language; transformation understanding other cultures that will display the role of intercultural communication within the hospital	1	10.0
Creating awareness among staff of the diverse cultures and how to treat each patient accommodating the differences	1	10.0
Developing motivation from other cultures to learn other languages; catering for and accommodating the Zulu culture	1	10.0
Formal and informal training on cultural diversity i.e. educational programmes and cultural celebration days and events	1	10.0
Getting both patients and staff to understand and recognise the difference and appreciate it	1	10.0

Group focuses with staff	1	10.0
N/A	1	10.0
Staff being more sensitive to the cultural needs/preferences of a patient; Getting more Zulu literature for Zulu speaking patients	1	10.0
Taking into consideration the comfort of a patient which is crucial; reviewing the English policy of the hospital	1	10.0

These findings indicate and suggest that the respondents recognised the importance of cultural sensitivity. The frequent occurrence of 10 % represents the common idea that is held by the respondents. Thus, it can be concluded that these measures could work to enhance the communication between health care workers and patients, considering the cultural diversity.

There is a strong interrelation of being culturally sensitive and being able to accommodate others with their own cultural variables which are different from the dominant culture. Therefore, cultural sensitivity provides a platform for understanding other cultures. Understanding and sensitivity makes an individual an effective communicator. It enhances how individuals interact with each other. According to Sorrells (2013: 3:4), culture is the vital component of communication that allows humans to be able to give meaning to experiences and also be able to express themselves. Sorrell's definition indicates that cultural sensitivity is crucial for the sender and receiver to be able to use accurate channels of communication, for the message not to be lost. However, choosing the right channels of communication to be used depends not only on the ones mentioned in Table 4.6, but also to other communication methods.

4.3.2.7 Communication methods for enhancing intercultural communication within the health care

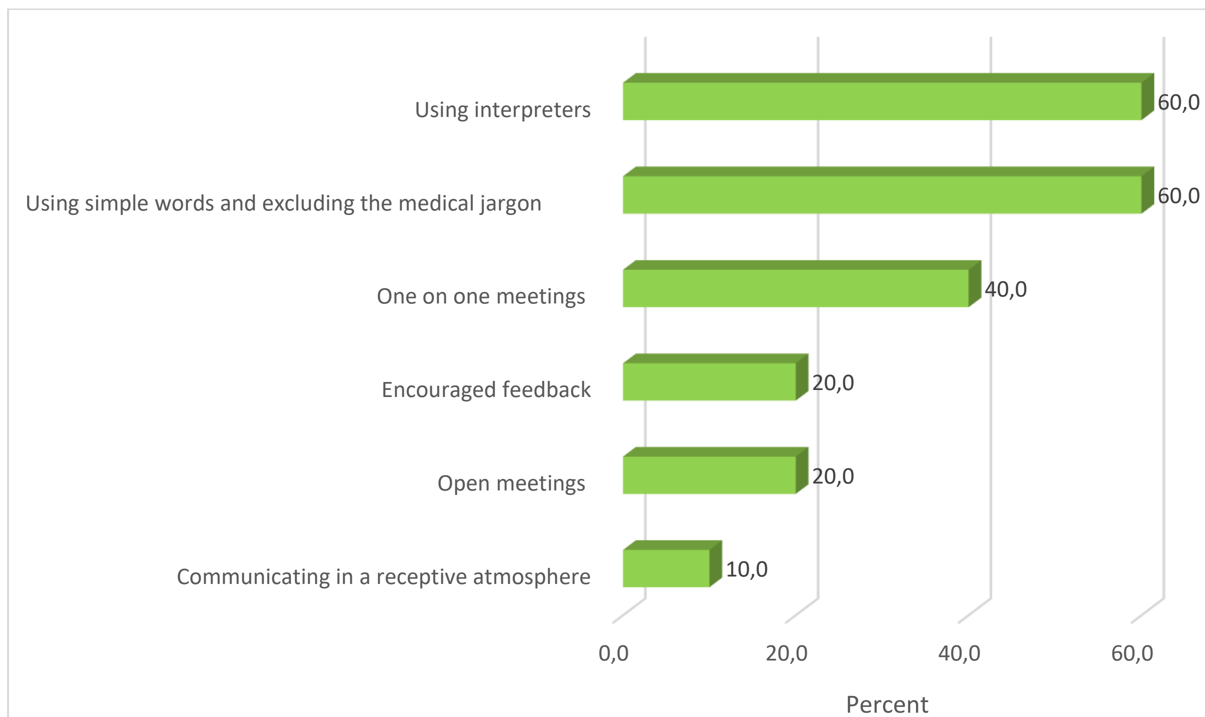

Figure 4.3: Methods of communication

The predominant suggestions are for "Using Interpreters" and "Using simple words and excluding the medical jargon" (both 60.0 %).

To justify the choices of the respondents given in Figure 4.3, the following were described as reasons for choosing the above methods of communication which can be utilised to enhance communication between patients and health care professionals:

- It must be considered that not all health care workers are bilingual, therefore English is used as the universal language, but interpreters should be used for other languages for the convenience of the patient.
- Language is the major barrier, thorough consideration and solutions need to be implemented for the benefit of the patient.
- Employing interpreters while limiting the use of the medical jargon will enable patients to comprehend what is communicated, which will then improve the communication between patients and the staff.
- Feedback from the patients will inform the health care professional whether the patient is satisfied or not.

- One on one meetings held with staff members will address all issues and cases which can potentially affect the patients' stay at the hospital.

4.3.2.8 Methods of communication (verbal, nonverbal and written communication methods) that have an effect on the understanding of messages between the patient and health care worker

Verbal

Table 4.7: Verbal communication in the health care

	Frequency	Percent
If what is said is not clear, misunderstanding can occur	1	10.0
Is vital in the sense that what is said must be clearly articulated	1	10.0
Misunderstanding of the language	1	10.0
Tone and choice of words are a focus in the hospital quality programme	1	10.0
Tone and good choice of words which display respect	1	10.0

Table 4.7 describes the frequency of positive answers to the questions. Verbal communication is the opposite of nonverbal communication. People use vocal words and non- vocal symbols to express thoughts and feelings. The respondents concur that in a case where verbal communication is unclear between the health care professional and patients' misunderstandings can occur. The miscommunication according to the respondent is a result of the language barrier, behaviour, and articulation. It is impossible to send any type of message which communication using a certain language. Since communication and culture cannot be separated, language and culture cannot be separated. Hamilton (2010) explains that language and culture can negatively impact on the achievement of contact during intercultural communication. When this occurs in professional settings, misunderstandings and communication breakdowns can have serious consequences.

Nonverbal

Table 4.8: Nonverbal communication in the health care

	Frequency	Percent
It promotes therapeutic relationship between the patient and the health care worker, hence there's focus on it	1	10.0
It's vital in a patient, they may respond based on how they read the nurse's body language which can cause a communication barrier	1	10.0
Low response from the staff, due to poor time management	1	10.0
Misinterpreting the body language of a patient/nurse by the patient can cause wrong conclusions	1	10.0
The patient being unable to understand the nonverbal signs displayed by the health care worker; misinterpreting of the signs	1	10.0

Neuliep (2009: 18) concurs that nonverbal communication is still communication in a sense that people still send messages to each other, but without verbal words. Neuliep (2009: 18) goes on to say that messages sent during nonverbal communication include those sent via body motions, the use of time, space, artefacts, smell and dress. Some patients may choose this form of communication, to avoid conflicts and misquotations and out of fear of being out spoken, which may be due to cultural teachings – in some cultures people are taught to be more passive while people from other cultures are taught to be active respondents and to understand the freedom of speech and action.

Written communication

Table 4.9: Written communication

	Frequency	Percent
Seldom used	4	40.0

Forty percent of the respondents indicated that written communication is seldom used in the hospital. This suggests that verbal communication is relied on more frequently than written communication. Written communication is a form of nonverbal communication, since there are no vocal words expressed in written communication.

In most cases written communication is interpreted based on how the message is delivered to the recipient.

People tend to interpret written messages depending on the state of mind and emotion they are at, the time they receive the sent message. For instance, a recipient in a happy state of mind may interpret, a question “why are you laughing?” differently from someone who is upset and has received the same message. It is for this reason that communication is regarded as a skill and a compulsory ability to interact with people. This is necessary in a health care context.

4.3.2.9 Communication abilities compulsory for patients and the health care worker

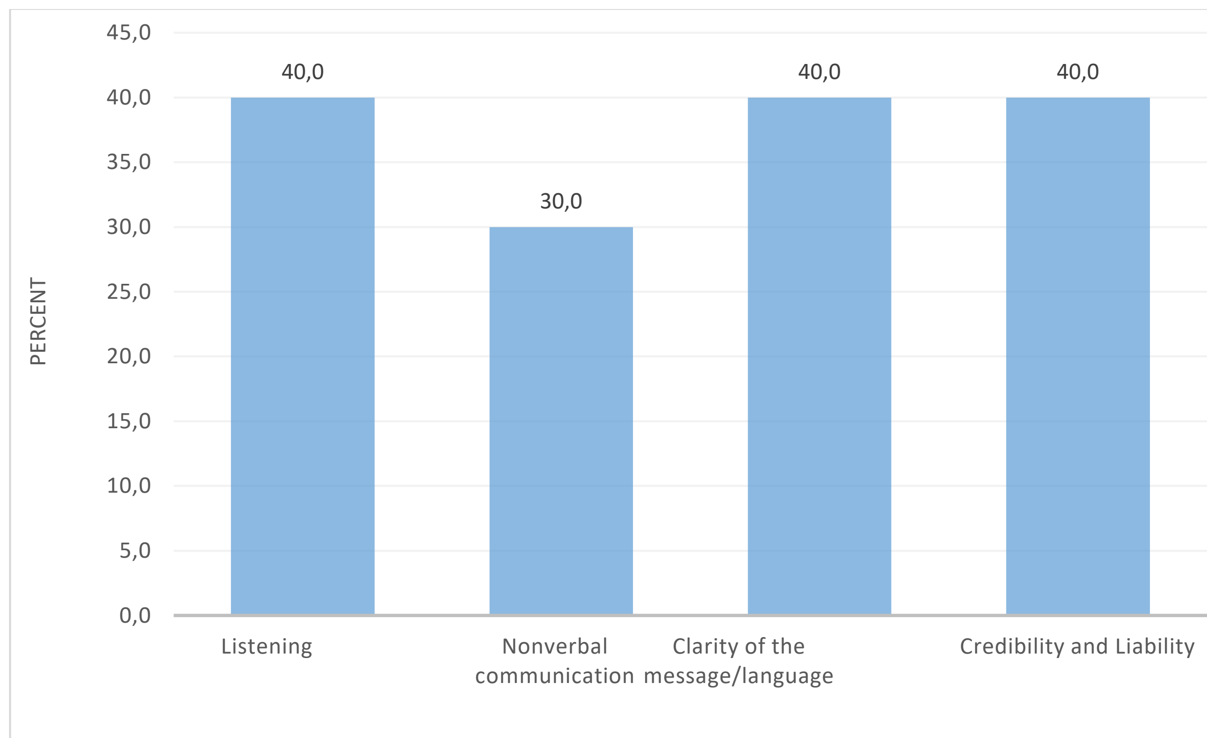

Figure 4.4: Effective communication skills

There was not much difference in the options highlighted by the respondents. Samovar, Porter and McDaniel (2013: 329) sustain that to provide accurate health care to patients is the goal of medicine; therefore, health care providers are expected to understand patients with different beliefs and values from their own. The skills

required for one to be an effective communicator are listed in Figure 4.4. The highlighted listening, nonverbal communication and clarity of message or language (all with 40 %), as well as credibility, as being the most important skills and abilities required within the health context. Thus, the skills mentioned in Figure 4.4 are necessary to provide effective communication within the hospital, for patients and the staff.

One respondent explained that when communication skills are accurate and effective, this creates a good atmosphere and builds trust between the health care worker and the patient.

4.3.2.10 Communication barriers in an intercultural communication environment

Sixty percent of the respondents responded to the question.

Table 4.10: The existence of communication barriers

	Frequency	Percent
Yes	4	66.7
No	2	33.3
Total	6	100.0

Table 4.10 indicates that 67 % of respondents agreed that they have had experiences where there were breakdowns in communication which were caused by certain communication barriers while engaging in an environment that allows intercultural communication. The environment in this context is the health care centre. However, 33 % disagreed and indicated that they have not experienced any break down of communication.

The 66.7 % who indicated that they had experienced break downs in communication identified the following reasons for this:

- Cultural insensitivity which was the result of intercultural communication ignorance.

- Miscommunication caused by the difference in language.
- Cultural shock – dealing with expectations from the patients which were based on their own (the patients') cultures.

Intercultural scholars have indicated that differences between individuals from diverse cultural backgrounds can cause problems of communication. Thus, it is imperative that parties involved in the communication process are aware and sensitive to diverse cultural backgrounds. Chaney and Martin (2011: 13) concur that factors that result in breakdowns in communication usually developed when one's conduct differs from the other person's.

4.3.2.11 Measures that can be used to avoid the communication barriers within the hospital

Table 4.11: Recommendation for the communication barriers

	Frequency	Percent
Adding isiZulu and not only relying on English language as the only language to communicate in	1	10.0
Creating motivation from staff to understand the languages of the patient; encouraging interaction and involvement of the patients with the staff	1	10.0
Eliminating ethnocentrism; using interpreters to ensure accurate dissemination of info to patients; emphasising on the cultural diversity which is part of the nursing curriculum	1	10.0
Learning other languages; understanding each other's expectations	1	10.0
Staff must be more patient and have the heart to work at the hospital; Encouraging staff to learn more about other cultures	1	10.0
Staff being motivated to learn other languages; getting more interpreters; emphasising the importance of communication to the staff; accommodating a patient's special needs	2	20.0

Table 4.11 shows the respondents' suggestions of measures that can be taken to eliminate and minimise breakdowns in communication. The largest proportion (20 %) indicated motivation of staff as being the most important factor. The other respondents identified the utilisation of interpreters and learning of other languages as being important. In other words, the respondents believe that if the staff of Entabeni Hospital are motivated to learn and be taught how to be sensitive to other cultures considering

language as the key element of communication, the breakdowns in communication could be minimised. Moreover, effective communication can be achieved through applying these recommendations.

4.3.2.12 Cultural variables that negatively affect the relationship between health care workers and patients

Table 4.12: Cultural variable negatively affecting relationship

	Percent
Race	50.0
Status	30.0
Language	70.0

As can be seen from Table 4.12, most respondents identified language as the most important factor that negatively affects the relationship between health care workers and patients, along with race and status. Language being the main factor suggests that communication through verbal and nonverbal symbols play a major role to the relationship between patients and health care professionals within Entabeni Hospital. This is appropriate in a sense that communication, which is sending messages from a decoder to encoder, is greatly dependent on language. For instance, a patient whose home language is IsiZulu, usually misses the messages communicated in English by a person for whom English is their first language. In medicine it becomes even a greater challenge as there are medical terms used, which most patients cannot translate. The language can also be associated with culture in sense that different racial groups have different languages as their first language before English, which is dominant in the hospital.

Respondents indicated that 50% of the negative effects on the relationship between the staff and patients result from race. The racial connotations were said to be from the patients' side: patients associated all treatment within the health care context as being racially biased. Only 30 % of respondents said that the cultural variable of status negatively affects the relationship between health care workers and patients.

4.3.2.13 Cultural variables that affect intercultural communication

After the previous questions based on culture, the researcher thought that there was a need for the respondents to describe the variables related to culture which they

perceive to affect intercultural communication. The participants displayed strong emotions on the variables which they view as crucial to consider and be aware of, as they affect communication within the hospital, and between staff and the patients.

The respondents explained that being intolerant of other cultures, and attaching that to race, causes conflict. The majority of the participants perceived that language is the major cause of communication breakdowns. The reason for the communication barrier was explained as being that the majority of the staff use IsiZulu as their main verbal communication, while the majority of patients prefer and can only comprehend a verbal message communicated in English. This becomes a challenge in events where an interpreter is not available.

Furthermore, the respondents indicated that the issue of race becomes a challenge, where patients associate every order from the health care professionals as associated with race. One of the respondents referred to an event where a patient was ordered by a staff member (nurse) to move to another ward with people with a similar illness as the patient. The ward the patient was currently in was mostly occupied by elderly people. The health professional explained that this was for the benefit of the patient and was done for the patient's comfort. However, the patient felt that it was based on race as the ward the patient currently in was dominated by a race different from the patient's. The respondent explained how the scenario had caused the patient to be emotional, as there was a misunderstanding.

The scenario explained in the previous paragraph describes how misunderstanding can affect a communication process. The event that occurred between the staff member and the patient, explains how perception and stereotypes caused by different cultural backgrounds results in misinformed conclusions. The cultural background of the patient, which includes the patient's worldview, which also relates to stereotypes, had influenced the reaction. Pearson (2013: 145) affirms that intercultural relationships are stalled by biases based on perception.

4.3.2.14 Defining stereotype

The respondents provided their own explanations and views of what the term 'stereotype' as follows:

- Attaching meaning to people based on their cultural background.
- Generalising.
- Having predetermined ideas about someone based on the cultural group that an individual comes from.

Jandt (2013 89) mentions that stereotyping causes people to assume that a general belief is accurate even when that is not always so. Furthermore, Jandt (2013) explains that stereotypes impede communication when it makes human beings believe the latter. Since the Entabeni Hospital works with individuals from different cultures, stereotyping will occur. It is ideal to understand how the staff from the hospital deals with cases where stereotyping occurs, from both health professionals and patients.

Only two respondents (20.0%) answered in the negative. The rest (80 %)answered positively and indicated that they had experienced stereotyping. Therefore, it can be concluded that stereotyping has occurred in most interactions between the staff and the patients within the hospital. As stereotype causes negative effects on communication, it then can be regarded as one of the major communication challenges within the hospital. However, it is imperative to note that stereotype defined as a generalisation stems from social belonging, which builds and shapes a person's worldview. The communication barrier can be associated with cultural shock.

4.3.3 Section C – Cultural shock

This section deals with the understanding of cultural shock and experiences relating to it by the health care workers in relation to patients.

4.3.3.1 Understanding Cultural Shock

Table 4.13: Understanding cultural shock

	Frequency	Percent	Valid Percent
Yes	9	90.0	100.0

All nine of the respondents who answered the question indicated that they had heard of the term and understood what cultural shock is about. The term emerged as a result of perceiver's expectations which are a subjective collection of all past experiences and accumulated life knowledge which then affects how these people interact with a given service that is of a standard quality (Reider 2016: 16). In an interview, conducted on 08 July 2016, Unit Manager 4, explained "One old Chinese man once came into the hospital as a patient, obviously seeking medical attention, and found it hard to adjust to the environment as it was his first time in a city and a private hospital. He resented assistance from the health care workers for weeks and this was greatly challenging as the staff didn't recognise immediate habits the man could familiarize himself with".

The unit manager explained how this went on for a while until the hospital organised for the man's family to visit for a while until the man was settled. Thereafter, the man was calm and could receive the service he required. This incident compelled the health care professionals to understand cultural shock and enabled the staff to provide explanations of what cultural shock is and how it can be addressed.

4.3.3.2 Explanations of cultural shock

The respondents provided the following explanations based on their knowledge of the term and their experiences:

- Feeling of being disconnected in an unfamiliar cultural environment.
- Fear of the unknown; not knowing what to expect.
- Experiencing shock due to being exposed to a new environment.

- Effects of diverse cultural ideas which influence reaction if exposed to a new culture.
- Finding something strange according to one's own beliefs and socialisation, while it is normal for the other.

According to Chaney and Martin (2011: 72) cultural shock is an event where one experiences trauma, as a result of moving from one's own culture to a new culture. It is evident from the definitions that the respondents have the correct understanding of what cultural shock is about. This suggests that they cannot be mistaken when it comes to recognising a patient experiencing the shock. However, the effect of the shock cannot be denied because it impedes the medical process.

4.3.3.3 Experiences relating to cultural shock during intercultural communication engagements between patients and health professionals

Table 14 describes some of the respondents' experiences of cultural shock.

Table 4.14: Experiences of cultural shock

	Frequency	Percent
A family which wanted to bring a fowl in a room where their member had passed on to ward off the spirit	1	10.0
A patient coming from a rural area being exposed to the modern environment	1	10.0
A patient who comes from a rural area being exposed to a modern environment; Zulu patients bringing sangomas to the hospital to perform rituals	1	10.0
A patient who speaks and different culture; patients' cultural practices which are against the hospital's rules; a patient who came with cuts on the face, which was their cultural practice	1	10.0
Elderly people who become resistant to the rules and practices of the hospital; Patients who for the first time are exposed to a multiracial modern environment	1	10.0
N/A	2	20.0
None	1	10.0
The food, the set up; having to share space with others	1	10.0

In response to Question 16, Table 4.15 represents the participants' thoughts on who usually suffers from cultural shock, health care workers or patients:

Table 4.15: Patients and health care professionals' experience of cultural shock

	Frequency	Percent
Both	7	70.0

Table 4.15 indicates that the majority (70 %) responded 'both'. indicating that respondents thought that cultural shock affects both the patients and heath care professionals. Therefore, it can be concluded that both patients and the health care staff suffer from the consequences of cultural shock. The positive side of this is that, there is an awareness of this negative element of communication. Thus, it can be assumed that there are complications caused by the communication barrier: cultural shock, to intercultural communication.

The 70 % that responded that cultural shock is experienced by both Patients and Health Care Workers identified the following complications which result from cultural shock:

- It affects the healing process for the patient.
- It affects and delays the communication process.
- It affects the understanding of messages communicated.
- It lowers a patients' personal confidence.

The complications somehow cause a negative effect on the wellbeing of the staff and the patients. Since this study focuses on a health care context, it can be comprehended that when communication is diluted by any negative aspect, the health of the patients can be at risk. Thus, it is vital that the staff of a health care context is aware of this kind of shock.

4.3.3.4 Consequences of cultural shock that have the greatest effect on intercultural communication between patients and health care workers

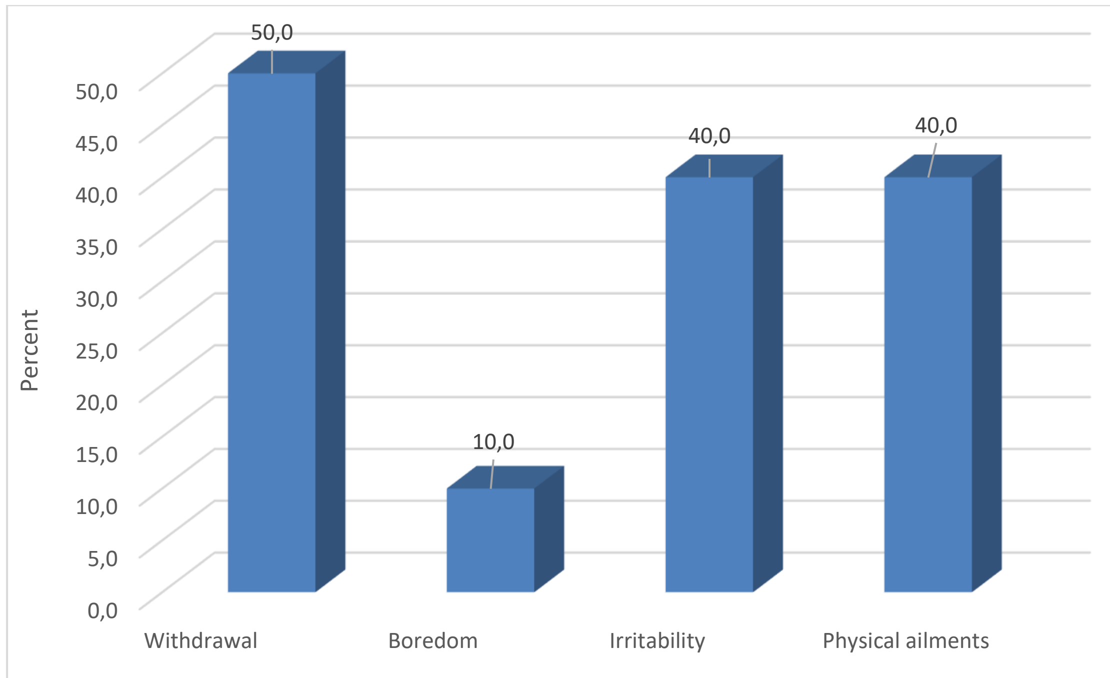

Figure 4.5: Effects of cultural shock

Figure 4.5 shows that half of the respondents highlighted "Withdrawal" (50.0%) as being the greatest effect of cultural shock, with the least effect being "Boredom" (10.0%). The findings suggest that most patients withdraw whenever they get into a new environment where they have no idea what to expect and are exposed to new practices. While the least effect of 10 % suggests that a small number of patients become bored as a result of the new experience. However, 40 % for irritability and 40 % for physical ailments indicated a number of patients and staff experience such effects indicating that irritability blends with sickness, weakness and other factors relating to the physical well-being of both parties.

4.4 Crosstabulations

This section explains the results from a quantitative point of view. The traditional approach to reporting a result requires a statement of statistical significance. A p-value is generated from a test statistic. A significant result is indicated with "$p < 0.05$".

A Chi square test was performed to determine whether there was a statistically significant relationship between the variables (rows vs columns). The null hypothesis states that there is no association between the two. The alternate hypothesis indicates that there is an association. There is only one crosstab that works.

Do you think intercultural communication exists within the Entabeni Hospital? * Do you understand the term intercultural communication?

Table 4.16: Crosstabulation

Crosstab

			Do you understand the term intercultural communication?		Total
			Yes	No	
Do you think intercultural communication exists within the Entabeni Hospital?	Yes	Count	5	3	8
		% within Do you understand the term Intercultural Communication?	71.4%	100.0%	80.0%
	No	Count	2	0	2
		% within Do you understand the term Intercultural Communication?	28.6%	0.0%	20.0%
Total		Count	7	3	10
		% within Do you understand the term Intercultural Communication?	100.0%	100.0%	100.0%

Table 4.17: chi-square tests

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	1.071[a]	1	.301	.533	.467	
Continuity Correction[b]	.030	1	.863			
Likelihood Ratio	1.632	1	.201	.533	.467	
Fisher's Exact Test				1.000	.467	
Linear-by-Linear Association	.964[c]	1	.326	.533	.467	.467
N of Valid Cases	10					

a. 3 cells (75.0%) have expected count less than 5. The minimum expected count is .60.

b. Computed only for a 2x2 table

c. The standardised statistic is -.982.

The Fisher's Exact Test p-value between “College has a risk management policy” and “Group” is 0.467. This means that there is no significant relationship between the variables. That is, the understanding of the term did not influence the existence of the term at the hospital.

An inspection of the frequencies in the crosstab table indicates that similar percentages are observed for the two column options.

4.5 Conclusion

This chapter provided results of the data collection. It described the respondents' answers to the questions that were developed by the researcher based on the objectives of the study and the literature relating to the topic of this study. The results were translated into tables and graphs. The next chapter will provide the recommendations which are drawn from the participants' responses. Furthermore, the next chapter will provide conclusions of the entire study.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The previous chapter provided the data analysis of the role of intercultural communication within a health care context. The data obtained from the research participants had been translated into graphs and tables. The chapter also provided descriptions of the tables and supporting statements from communication, culture, intercultural communication and health care scholars, as well as researchers, to justify the data obtained. This chapter will provide the conclusions by the researcher, which are based on the previous chapter. It will also offer recommendations and a summary, which serves as a review of the study.

5.2 Summary of the study

The study was based on culture and communication, incorporated as intercultural communication, in a health care context. This study overall aimed at analysis of the interaction between culture and communication. Through the literature obtained, the researcher aimed to identify and investigate the role of intercultural communication in a health care context. In particular, this research study's objective was to analyse the relationship between health care professionals and patients of Entabeni Hospital in Durban, KwaZulu-Natal, and to identify the existence of intercultural communication within that context. This was accomplished through identifying the role of communication between individuals from different cultural backgrounds, describing the influence of the cultural variables of language, race and class.

5.3 Conclusions

The overall aim for the study was to examine the role of intercultural communication in a health care context and how the relationship between health care professionals is

affected by diverse cultural backgrounds. Arising from this, the following conclusions were made based on the findings, related to the sub-objectives identified in Chapter 1

- Investigate the existing relationship between health care professionals and patients from diverse cultural backgrounds: health care workers do have a relationship with their patients. However, the relationship is hindered by a number of challenges, which can be associated with cultural signs and symbols. Furthermore, the challenges have a negative effect on the communication process, which derails the strength of the relationship. Although, the unit managers may not have access to all the patients' or staff members' personal information, they do make an effort to manage the relationships using various approaches. Therefore, it can be concluded that patients and health care workers do not necessarily have in-depth relationships, where there is understanding, and an easily relatable interaction. The relationship is merely professional, between a service provider and their client.

- Investigate the significance of promoting intercultural awareness: the data collection and analysis indicated that the staff of Entabeni as well as the patients are ignorant of what intercultural communication is. Intercultural communications have a minimal influence in the health care context. Only a few of the staff members have done training on intercultural communication. The rest are not aware which explains why most of the staff cannot culturally relate to their patients. Therefore, the conclusion that can be drawn here is that intercultural communication awareness is not promoted in this particular context.

- Identify challenges and possible consequences related to intercultural communication within a health care context: the major challenges within the context were the language barrier and racial related influences. The conclusion that can be drawn from this is that in a health care environment, language is the main reason for miscommunication, whether it is the use of jargon or different languages spoken.

5.4 Recommendations

Based on the findings from the data collection, and the data analysis extracted therefrom, the following recommendations are made:

- Intercultural communication is the foundation of communication in a multiracial environment, where different individuals from different cultural backgrounds come into contact. In a health care context, people from different racial groups, speaking different languages, with different levels of social class or status interact. Cultural variables have an intense effect on the context in which a message is transmitted and on how the feedback is received, as well as the type of feedback obtained. Therefore, it is crucial that patients and health workers are aware of what intercultural communication is, what it entails, how effective it is in a health care environment.

  Health care workers and patients knowing this type of communication will allow them to predict or avoid any potential communication that could hinder the medical process, which requires clear communication. From the literature one scholar mentioned that the message is the foundation and the most crucial part of a communication process, thus ensuring that both parties (sender and receiver) are clear on what message is communicated. For instance, at Entabeni Hospital, most health care workers are not multi-lingual, which affects the communication between them and the patients, as clarity is strained by the difference in language, and stereotyping related to racial discrimination.

  Scholars of communication mentioned that unclear communication in the health care context can be fatal. So, to stress the importance of clear message communication, it can be said that a clear message stimulates effective communication, which prompts feedback. In any sector, feedback is imperative, as it can improve the level of services provided. The hospital therefore needs to prioritise interpreters, alternatively, the staff needs to be taught cultural sensitivity.

- Intercultural communication allows for and promotes cultural sensitivity within any context. When people participating in the communication process are well informed regarding cultural diversity and what the subject of culture entails of, as well as the characteristics of both culture and communication, it becomes easier for the parties involved to identify the differences.

  Identifying the differences and being well informed regarding the various cultural variables that may potentially negatively or positively affect communication, is good practice. The elevation of intercultural communication within the health care context can enhance the communication between health care professionals and patients. In addition, the practice of intercultural communication creates an environment that says, "it's ok, you can be yourself". Consequently, patients can feel at ease with the health care workers, which can lead to a mutually beneficial relationship.

- It is naturally believed that trust is the foundation for all relationships. Therefore, this may apply in the health care context as well. When patients are made to feel comfortable in the presence of other, regardless of the difference in race, language and status, they develop trust. This trust enables the individuals to interact better and be able to provide input on what is relevant to their interests. Depending on the relationship between health care workers and patients, there can be passiveness or activeness from the side of patients. If patients do not fully participate in the process, the whole medical process may be hindered.

  It is imperative that the relationship between parties is built on a concrete foundation. In addition, the relationship should be frequently evaluated, in order to avoid potential negative consequences. Health care workers should ensure that there is a good relationship between them and their patients. This relationship needs to be nurtured, as it is sensitive, concerning the wellness of a human being. It is also essential that the encoder and the decoder remain aware of the challenges that may occur.

- The challenges experienced within the health care context which include language and racial questions, can be avoided. Regarding the language barrier; interpreters could be hired to translate the vernacular languages which are understood by only a few of the staff. Alternatively, the staff can register for language courses. A second language should be an essential requirement in recruitment of health care workers in a context where there is a dominant language spoken other than English. Looking at the racial questions, there needs to be more awareness and sensitivity of the cultural differences which the patients bring into the setting. There should be more emphasise on the study of intercultural communication study, for all health care workers.

  Patients should be given more platforms to express their experiences within health care centres. This should be done to identify the problems so that measures can be taken to solve any problems raised. To avoid communication breakdown, which can be a result of cultural diversity, more attention should be payed to nonverbal signs, while also being mindful of owns body language. In addition, more effort should be made to involve patients by asking them questions like “are you ok with this, or that, what would you prefer”, adjusting the communication to each person’s level of understanding and perception. These measures could reduce anxiety, which in most cases is a result of cultural shock.

  Since a health care context is an environment dealing with emotional and physical well-being, being aware of the patient’s emotions is vital. A patient’s state of mind and emotional state can have a huge impact on how they relate to the context, which dictates their behaviour. Encouragement may play a major role in this regard.

5.5 Conclusion

This chapter has summarised the nature of the study. It provided a brief description of the objectives of the study. Furthermore, this chapter described the recommendations, based on the findings arising from the data collection analysis. In addition, conclusions were drawn, and recommendations made.

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APPENDICES

Appendix 1: Questionnaire

Voluntary questionnaire for Entabeni Hospital in KwaZulu-Natal-Durban in South Africa

INTERCULTURAL COMMUNICATION: A STUDY ON THE ROLE OF INTERCULTURAL COMMUNICATION IN A HEALTH CARE CONTEXT

Department of Management SciencesDurban University of Technology

Researcher: Thobile Mokoena (Student No. 20912941)

Supervisor: Dr P. Naidoo

NOTE TO RESPONDENT

- I am registered student at the Durban University of Technology studying towards a Master's Degree in Public Relations.
- This is a voluntary and confidential survey.
- The information that will be provided as feedback on the questionnaire will be private and confidential.
- The findings in this investigation will be used in developing and enhancing intercultural competence between the patients and the health care providers.
- This questionnaire consists of three sections:
- Section A – This section seeks permission to use your responses for research purposes.
- Section B- This section seeks information of your understanding on intercultural communication and its influence on the relationship of the health care workers and patients.
- Section C- This section asks you to identify the possible consequences of intercultural communication and your understanding of cultural shock.
- Please complete all the sections and carefully read and respond to the questions.

Thank you for your participation

Student : Thobile Mokoena

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E-mail: thobilemokoena@ymail.com

Questionnaire for Entabeni Hospital Staff

SECTION A – Permission to use my response for academic research

This section is necessary to provide information that proves that a real person completed the questionnaire. Any information provided will be private and confidential and used with discretion; no names will be linked to responses.

I hereby give permission that my responses be used for research purposes: Yes No

5.6 SECTION B

Please complete the following section regarding intercultural communication within the Entabeni Hospital. [Tick the appropriate box where necessary]

1. Do you understand the term Intercultural Communication?

   Yes

If yes, explain your understanding of intercultural communication.

____

____

____

2. Do you think intercultural communication exists within the Entabeni Hospital?

   Yes

   If yes, explain the different scenarios that you experienced that helped you conclude that intercultural communication exists within the Hospital.

____

____

____

3. In your opinion, is communication an important component at the Hospital?

Yes ☐ No ☐

Explain your answer.

____

____

____

4. What do you think can enhance communication between health care workers and patients from diverse cultural backgrounds?

____

____

____

5. From your experience, what is viewed as causes for poor communication between health care practitioners and patients coming from diverse cultural backgrounds?

____

____

____

6. Indicate frustrations that you may have encountered during your interaction with patients?

____

____

____

6.1 With response to question 6, explain how you would you have dealt with those frustrations?

____

____

____

7. Which of the following methods of communication do you think will enhance intercultural communication within the health care? (Tick the appropriate box/s.)

One on one meetings ☐
Open meetings ☐
Using simple words and excluding the medical jargon ☐
Using interpreters ☐
Communicating in a receptive atmosphere ☐
Encouraged feedback ☐
Other ____

7.1 Explain your response to question 7.

____

____

____

8. Have you experienced any communication barriers when engaging in an intercultural communication environment?

Yes ☐ No ☐

If yes, please explain

____

____

9. What do you think should be put in place to avoid the communication barriers?

____

____

____

10. Which of the following cultural variables do you think can negatively affect the relationship between health care workers and patients?

Race ☐ Other ☐

Status ☐

Gender ☐

Language ☐

10.1 How do think the above affect intercultural communication?

____

____

____

11. Please explain your understanding of the term: stereotype?

____

____

12. Have you encountered any stereotype behaviour during your communication with patients? Please tick the appropriate box

☐ Yes No ☐

if yes please explain how this type of behaviour affected the communication between yourself and the patient

____

____

13. How do you think the following methods of communication (i.e verbal, non-verbal and written communication methods) affect the understanding of messages between the patient and health care worker?

Verbal:

____

____

____

Non-Verbal:

___

___

___

Written Communication

___

___

___

14. Which of the following communication abilities do you think are compulsory for interaction between patient and health care worker?

Listening ☐

Nonverbal communication ☐

Clarity of the message/language ☐

Credibility and articulation ☐

14.1 How do you think the above communication abilities contribute to effective communication in the hospital?

___

___

___

5.6 Section C

Please complete this section on cultural shock.

15. Do you have any understanding of the term cultural shock? Tick the appropriate answer

Yes ☐ No ☐

15.1 If yes, please explain your understanding of the term cultural shock?

___

___

___

16. During your intercultural communication engagement with patients have you experienced cultural shock? If yes, explain your experience.

____

____

____

16.1 In response to question 16, who do you think suffers from cultural shock between health care workers and patients? Please explain

____

____

____

17. What complications do you think cultural shock can cause to both patients and health care workers' well-being?

____

____

____

18. Which of the following consequences of cultural shock do you think are mostly to have a greater effect on intercultural communication between patients and health care workers

Withdrawal ☐

Boredom ☐

Irritability ☐

Physical ailments ☐

18.1 Explain how the above affects the communication between health care workers and patients.

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Thank you for your time and participation

Appendix 2: Approval for research study

22 September 2014

ATTENTION: T MOKOENA

APPROVAL FOR RESEARCH STUDY

TITLE: The role of intercultural communication in a health care context.

Our previous correspondence refers.

The Research Committee of Life Healthcare has granted permission for your study to be conducted within the company's facilities. Permission has also been obtained from the Hospital Manager of Life Entabeni Hospital where you wish to conduct your research (see attached document).

Please contact Mr Greg Swale (Hospital Manager, Life Entabeni Hospital) to arrange the details for your research.

We look forward to seeing the results of your research once it is completed.

Yours sincerely

Anne Roodt
Education Specialist

Life College of Learning