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INTEGRATIVE REVIEW ARTICLE

COMMUNICATION BETWEEN HEALTH PROFESSIONALS-DEAF PEOPLE: AN INTEGRATIVE REVIEW

COMUNICAÇÃO ENTRE PROFISSIONAIS DE SAÚDE-PESSOAS SURDAS: REVISÃO INTEGRATIVA

COMUNICACIÓN ENTRE LOS PROFESIONALES DE LA SALUD-LAS PERSONAS SORDAS: UNA REVISIÓN INTEGRADORA

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ABSTRACT

Objective: analyzing the scientific studies published about the process of communication of deaf people in health services. ***Method:*** an integrative review, held in 2011 in LILACS, IBECS and MEDLINE, guided by the question << ***What are the potentials and limitations of the process of communication of the deaf in Brazil's health services?*** >> In the analysis of the nine articles, prioritized the characterization of the studies. We proceeded to the clipping and grouping of units of interest according to the similarity of their central ideas. From this perspective, four themes emerged: communication, considerations of the deafs, and considerations of professionals and autonomy of the deafs. ***Results:*** there were identified the predominance of qualitative approach and the use of the deaf themselves as participants; communication is a problem in access to health by the deaf. ***Conclusion:*** the difficulty of communication is a limited autonomy of the deafs and represents a risk to their health. ***Descriptors:*** People with Hearing Disabilities; Communication; Healthcare.

RESUMO

Objetivo: analisar estudos científicos publicados sobre o processo de comunicação dos surdos nos serviços de saúde. ***Método:*** revisão integrativa, realizada em 2011, nas bases LILACS, IBECS e MEDLINE, norteada pela questão **<< *Quais as potencialidades e limitações do processo de comunicação dos surdos nos serviços de saúde do Brasil?* >>** Na análise dos nove artigos, priorizou-se a caracterização dos estudos. Procedeu-se o recorte e agrupamento de unidades de interesse de acordo com a semelhança das suas ideias centrais. Nessa perspectiva, emergiram quatro núcleos temáticos: Comunicação, Considerações dos surdos, Considerações dos profissionais e Autonomia dos surdos. ***Resultados:*** identificou-se o predomínio da abordagem qualitativa e da utilização dos próprios surdos como participantes; a comunicação é uma problemática no acesso dos surdos à saúde. ***Conclusão:*** a dificuldade de comunicação constitui uma limitação à autonomia dos surdos e representa um risco para a saúde destes. **Descritores:** Pessoas com Deficiência Auditiva; Comunicação; Assistência à Saúde.

RESUMEN

Objetivo: analizar los estudios científicos publicados acerca del proceso de comunicación de sordos en los servicios de salud. ***Método:*** una revisión integradora que se celebró en 2011 en LILACS, IBECS y MEDLINE, guiada por la pregunta << ***¿Cuáles son las potencialidades y limitaciones del proceso de comunicación de los sordos en los servicios de salud de Brasil?*** >> En el análisis de los nueve artículos, priorizado la caracterización de los estudios. Se procedió el recorte y agrupación de las unidades de interés según la similitud de sus ideas centrales. En esta perspectiva, surgieron cuatro núcleos temáticos: comunicación, consideraciones de los sordos, consideraciones de profesionales y la autonomía de las personas sordas. ***Resultados:*** identifican el predominio del enfoque cualitativo y el uso de los propios sordos como participantes; la comunicación es un problema en el acceso de las personas sordas a la salud. ***Conclusión:*** la dificultad de la comunicación es una limitación a la autonomía de las personas sordas y representa un riesgo para su salud. ***Descriptores:*** Personas con Discapacidad Auditiva; Comunicación; Cuidado de la Salud.

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INTRODUCTION

The historical process of disabled people in society is characterized by distinct periods of exclusion, segregation, integration and inclusion. The latter, however, only started in the 1980s and is still in full discussion. Comes from the idea that the family and society must adapt to the needs of all people, whether they have disability or not, as people with disabilities can develop and exercise their citizenship with autonomy and freedom in a society in which they have rights and duties.[1]

According to Census of the Brazilian Institute of Geography and Statistics (IBGE), in 2010, Brazil had 23,92% of its population being referred to as poor, and of these, 21,31% had some type of hearing loss.[2] These data show the importance of the deaf population, which needs special attention.

For the deaf person, the communication mode used by the medium that surrounds is not presented as a resource that will facilitate its exchange with the world, but an obstacle that needs to overcome difficulties to achieve sociability effectively .[3]

Communication can be considered as an essential tool for the development of humanity and an important intervention tool in health.[4]

A milestone that shows the progress of the achievements of the deaf movements is mentioned in Decree Law No. 5.626/2005, which officially recognizes the Brazilian Sign Language (Libras) as the language.[5] Pounds is a significant role in the lives of the deaf person, leading it through a structured language, to fully develop.[6]

Regarding the process of communication between patient and health professionals, means that there must be efficient to allow humanization and personalized service according to the demands of the person receiving assistance.[7] In this perspective, communication barriers can for patients in risk, in different situations and hinder adequate care, which is essential for the quality of health services.[8] Given the above, it was aimed to analyze published scientific studies on deaf communication process in health services.

The study is relevant because it focuses on communication between the deaf and health professionals, a phenomenon that remains one of the difficulties in the care of this social segment. In addition, it is expected to generate information that may guide professionals in health care practice for deaf people, thus contributing to the local planning of services.

METHOD

The developed research is the type of integrative literature review, a broad review study method, in which you can include concurrently manuscripts derived from experimental research and non-experimental, enabling an understanding of specific phenomenon, through the results shown in each article.[10]

To develop the study there are considered the precepts of evidence-based practice (EBP), which consists of the conscious use of the most reliable evidence about a particular object of study for future decision making. Thus, followed by the six stages recommended in the literature for integrative reviews: questioning the integrative review; literature search; categorization of studies; assessment of studies included in the review; interpretation of results; and synthesis of knowledge evidenced in the analyzed articles.[11]

The survey was conducted in 2011, through a search in indexed journals, by two reviewers/ independent evaluators in electronic databases LILACS, IBECS and MEDLINE. There were used the following descriptors in Health Sciences (MeSH): hearing impaired persons, deafness, hearing loss, health care, health and access to communication services.

For forming the largest number of articles that could answer the question "How is the communication process of the deaf in Brazil's health services?" implemented by three search strategies: 1. Crossing by descriptors: (People with Hearing Impairment OR Deafness OR Hearing loss) AND (Health care OR Access to Health Services OR Communication); 2. Crossings by words: Deafs AND Health Care; Deafs AND Health Services; and 3. Review of the bibliography of the selected articles.

Scientific articles published by health professionals were included in Portuguese or English that deal with care for the deaf in the health services in Brazil, available in its entirety via internet, for free, from 2000 to 2010. Then, proceeded to read the titles and abstracts of identified articles, among which articles were excluded clinical discussion of deafness or hearing loss, review articles, monographs, dissertations, theses, books and book chapters.

Excluding the studies that were repeated in more than one base or cross, formed a sample of nine articles, the management takes place

through the JabRef Reference Manager Software version 2.5. the collection process was performed using an adaptation of an already validated instrument.[12]

To categorizing the items according to the level of evidence of the studies, there were used the American Hierarchical Classification of Evidence: Level 1: meta-analysis of multiple controlled studies; Level 2: individual study with experimental design; Level 3: study with quasi-experimental design to study without randomization with one group pre and post-test, time series or case-control; Level 4: study with a non-experimental design as correlational and descriptive qualitative research or case studies; Level 5: report of cases or data obtained in a systematic, verifiable quality or program evaluation and data; Level 6: opinion of respected authorities based on clinical competence or opinion of expert committees, including information not interpretations based on research.[9]

For the analysis of the material, we proceeded to the cut and grouping of units of interest according to the similarity of their central ideas. From this perspective, four themes emerged: communication of the deaf considerations, considerations of professional autonomy and the deaf.

RESULTS

As shown in Figure 1, at the first intersection and were found 3.500 articles, at the second intersection, 786, totaling thus a number of 4,286 manuscripts. Rejected articles for this review were as justifications as follows: Previous work to 2000 (n = 2.517), studies with clinical or educational approach to deafness (n = 1.721), work done in other countries (n = 31) and repeat pre-selected texts (n = 10). Of the ten selected, eight are from the first intersection and two of the review of bibliographies of articles.

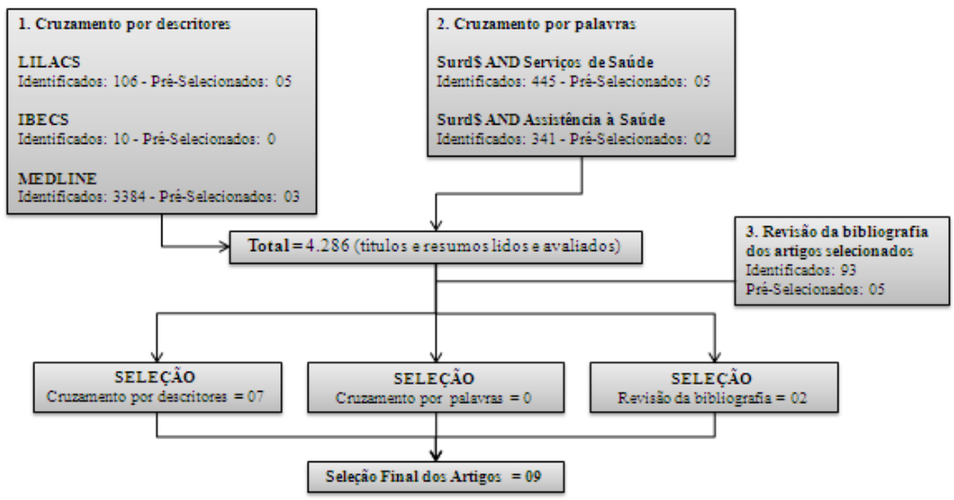

Figure 1. Flowchart of the selection of articles. João Pessoa, 2011

In Figure 2, we observe the articles selected by the author, title, year of publication, the state of completion of the study and publishing the magazine. Based on this description, there is a predominance of works on the subject of the hearing impaired in the Midwest region, in the State of Goiás (50%), and South, between Rio de Janeiro (20%) and São Paulo (20%).

A	PA	Title of the article	Year	State*	Journal
A1	Rosa CG.	Communication from the nursing staff with hearing impaired with severe deafness: an exploratory study	2000	Goiás	Electronic Journal of Nursing
A2	Barbosa MA.	Brazilian sign language: a challenge for the nursing care	2003	Goiás	Nursing Journal UERJ
A3	Santos EM.	The health needs in the world of silence: a dialogue with the deaf	2004	Rio de Janeiro	Electronic Journal of Nursing
A4	Chaveiro N.	Deaf assistance in the area of health as a factor of social inclusion	2005	Goiás	Journal of the Nursing School of the University of São Paulo
A5	Cardoso AHA.	Perception of the person with severe deafness and/or deep about the communication process during their health care	2006	Goiás	Latin American Journal of Nursing
A6	Pagliuca LMF.	Aspects of the nurse's communication with the hearing impaired	2007	Ceará	Journal of the Nursing School of the University of São Paulo
A7	Costa LSM.	Health care through the eyes of the deaf person: evaluation and proposals	2009	Rio de Janeiro	Journal of the Brazilian Society of Internal Medicine
A8	Ianni A.	The deaf community access to basic health network	2009	São Paulo	Health and Society Magazine
A9	Pereira PCA.	*Communication and information barriers to health assistance for deaf patients*	2010	São Paulo	*American Annals of the Deaf*
A10	Chaveiro N.	The deaf person who uses sign language, from the perspective of health professional	2010	Goiás	Cogitare Nursing

Figure 2. Description of selected articles. João Pessoa, 2011; *Place (State) of study performance; A=article; PA=first author.

Regarding the presentation of the description of the articles, it was observed that in nine manuscripts, the authors opted for qualitative approaches to the process of communication with the deaf and that in six (A3, A4, A5, A7, A8 and A9) used as participants the deafs themselves as well as other actors (A5 - health managers). Work A1, A6 and A10 approached the opinions of health professionals. And the study A2 worked out with the issue of professional training, they were learning Pounds. It was found also that all studies present evidence level 4, ie they were qualitative and/or descriptive studies. The choice of the deaf participants, it was noticed variety of media used: a deaf professional institution (A3 and A7), students of a special school (A4), church-goers (A5), community leaders (A8) and health care users (A9). However, all deaf communicated in Pounds and were aged less than 18 years.

As for the instrument used, showed the preference for the interview in Pounds, with semi-open questions in which the positive and negative experiences of the deaf in the health services is explored-the process of communication with professionals as well as their satisfaction patients with the services offered.

As shown in Figure 3, we identified the articles as is the access of the deaf to health services, the emerging themes: communication, deaf considerations, considerations of professional autonomy and the deaf. In them we see a convergence in the results, where the difficulty of communication is evidenced by all the work, as the strongest barrier of the deaf access.

COMMUNICATION
✓ Deaf access barrier to health services. (A3, A4, A5 e A9)
✓ Difficulty of establishing effective communication – link, dialogue. Lack of understanding of both the deaf and of health professionals, compromising the humanization in service. (A1, A2, A3, A4, A5, A6, A7, A9 e A10)
✓ Professional attitude while warm (same as complaints of patients listeners): technical terminology, not to look in the eye of the patient, do not have patience to hear, apply only to escort. (A5, A7 e A9)
✓ Lack of communication making it inaccessible to health information. (A3, A4, A7 e A10)
✓ Establishment of effective communication of the deaf restricted to people who understand your language, culture and differences. (A1 e A9)
✓ Shares of professionals that hinder communication with deaf: unreadable font, deaf non-literate, mask use during the conversation, talking fast. (A4, A5, A7 e A9)
✓ Strategies to minimize this barrier: speak slowly looking for the deaf, use mime and gestures, writing with legible and simple words, ask for help to an escort or interpreter, and keep numeric board in the waiting room. (A1, A4, A6, A7 e A8)
✓ The presence of the interpreter during the service: better understanding, dialogue between the deaf patient and the health professional. However, there is the difficulty in getting interpreters at health services and also, shame in exposing the intimacy to third parties. (A3, A4, A5, A7, A8 e A10)
✓ Suggestions to resolve this problem: campaigns and educational lectures on non-verbal communication, deaf culture-Pounds and how to proceed with these patients; dissemination of the alphabet for the deaf; pound lessons at the University and the presence of an interpreter at health services. (A2, A3, A4, A5 e A6)
✓ Laws governing the right to proper treatment and care, with the presence of an interpreter of pounds in public services. (A3, A5 e A7)
AUTONOMY OF THE DEAFS
✓ Reliance on third parties to achieve compliance. (A4, A5, A9 e A10)
✓ Limitation of autonomy: the listeners (professional and/or escorts) tend to make decisions about the body or health of deaf, without understanding the same. (A3, A4, A5, A7 e A9)
✓ Access to health information (health education) increases the autonomy of the deaf, preparing them to defend themselves and make conscious choices regarding their way of living. (A3, A7 e A9)
CONSIDERATIONS OF THE DEAF
✓ A negative impression of health services. (A3, A5 e A9)
✓ Feeling of anguish, social exclusion and disrespect as their needs. (A3, A4, A5, A7, A8 e A9)
✓ Fear of being wrong, taking wrong medication. (A5, A7 e A9)
✓ Fear of suffering discrimination because they don't understand what the professionals say or write, reaction of indifference and impatience of professionals. (A4, A5, A6, A8 e A9)
✓ Questions, need for more information about health and about what happens with their body. (A3, A7 e A9)
✓ Satisfaction when faced with professionals who seek to establish a dialogue. (A6 e A7)
✓ Necessity of acceptance of their language and culture. (A3, A5, A7 e A9)
CONSIDERATIONS OF HEALTH PROFESSIONALS
✓ Sense of unpreparedness, discomfort and disability by not being able to communicate with the deaf patient to handle this situation. (A1, A2 e A6 e A10)
✓ Wish to communicate, be patient, and get help. (A1, A2 e A6)

Figure 3. Thematic axes generated as results of selected articles. João Pessoa, 2011.

There are featured the following aspects related to communication: the actions of the professionals that limit communication with the deaf; the strategies used to minimizing the communication barrier; the interpreter during the service and tips to enhance this problem. As for the autonomy of the Deaf, emphasizes the limitation of the right of decision aids, due to the need for a third party to the call, and the tendency of listeners (professionals and companions) decide on health and the body of the deaf. With regard to the considerations of the Deaf, there is a strong account of the sense of exclusion and disrespect to their needs; fear of suffering discrimination by professionals and need for acceptance of their language and culture. The Professionals considerations also show feeling of unpreparedness and discomfort because they cannot communicate with deaf patients, but expressed willingness to interact and get help.

DISCUSSION

It is noticed that the access of the deaf to health services still presents many problems related mainly to the communication process, awakening adverse feelings (anxiety, fear, discomfort, etc.) that hinder the construction of the link between health professionals and deaf patients, which consequently hinders the

proper and comprehensive care, which is essential to all.[13]

From a clinical point of view, deafness classification is inconsistent with the needs of health promotion strategies, the extent to which members of the deaf community define deafness as a cultural, rather than just a hearing problem. Thus, one can see that deafness implies diversity, which, in turn, must be recognized, understood and respected.[14]

In Brazil, Health is a right and duty of the State to everyone, guaranteed by the SUS, which has as one of its principles, equity. This principle is based on the idea that all individuals of a society should have equal opportunities to develop their health potential, so that the system becomes responsible to act against obstacles to reduce avoidable or unfair differences between individuals. Thus, for a person with disabilities, the principle of equity would be a way to encourage people with disabilities to have equal opportunities.[15]

However the difficulty of access to health services is so evident in Brazil and in other countries. Studies in the United States also indicate the difficulty of access for the deaf to health services which is justified by the communication barrier and the economic condition, since, by deaf have low educational level, and have low wages. In other countries, health services are private, so access is also restricted by socio-economic factor.[16-7]

Recognizing and understanding the cultural, linguistic, educational, psychological and social aspects is the first step in providing health care quality for deaf people.[14] The findings about the difficulties of communication, strategies to minimize communication barriers and the need interpreter in services are also found in other studies,[14,18-9] and show thus for a similarity of results of studies conducted in Brazil and other countries.

In a study[18] it was reported the difficulty of health professionals, especially nurses, to assisting the deaf, for lack of preparation, information about the deaf culture and the difficulty of communication, confirming the findings of the articles. Nurses reported feelings of anxiety, anguish and helplessness when faced with patients who are unable to communicate. These feelings cannot disrupt the service and, therefore, show the need to discuss this issue since graduation, so that they feel prepared for a full and humanized care.

Fit for professional health further reflection on human diversity, so that in this way the barrier between them and the deaf patients is reduced and there is the possibility of acceptance of their language as well as their form of communication, not just dominating theoretical concepts related to hearing impairment.[20] Practitioners should be aware of the implications of deafness, and obstacles to overcome to provide a humanized and comprehensive care to people with hearing loss.[14]

To minimizing the difficulties of communication, generally, there are used some strategies as the use of writing, speak slowly, be patient or seek companions/family to facilitate understanding with these patients.[18] However, some of these strategies are considered inadequate for not achieve an effective dialogue, but a partial transfer of some information.[8,17] Another study[19]confirmed the findings of the articles made in Brazil, and also exposes the problem of dependence of a companion in the care of deaf patients, showing that does not always allow the deaf to speak frankly about matters that require discretion and confidentiality.[1]

The reason for the problem shown due to lack of knowledge and misinformation of health professionals from both the public and private network, with the problems of disabled people, their needs and expectations of their families.[21]

Decree No. 5.626/05, became the inclusion of pounds as a compulsory curriculum subject in teacher training courses, degree and speech therapy, and as optional course discipline in other higher education courses and vocational education, public and private educational institutions.[5] This measure can provide both the acquisition of knowledge with potential to change the attitudes of these professionals regarding the care provided to deaf people, their families, as well as greater interaction in professional contact situations with deaf colleagues, which will help for a professional performance optimization, health care and the care act. Work will be so, with primacy, the basic principle of the National Health System, which is to serve all according to their specific, expectations and needs.[22]

CONCLUSION

This study showed that communication is still an important issue in the access of the deaf to information and health services, and as such, is also a limit to the autonomy of people with hearing disabilities.

This barrier is a risk to the health of the deaf, and a greater distance of this from society. This factor may have negative feelings about the services and health professionals, and the feeling of social exclusion disrespect to their culture and language.

It was found that communication with the deaf is a complicated and difficult process both for professionals and for the deaf, being notorious that even with so much evidence and legal backrests, the change of reality, although gradual, is very slow.

It is suggested that health services promote qualifications as service deaf patients, and the availability of interpreters' services. Understanding the importance of this process, it is necessary that the care for the deaf be addressed since graduation, to raising awareness and preparing professionals for proper care, integral and humanized.

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