Culture and (mis)communication
A study of doctor-patient interactions and emotion

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Acknowledgements

This master thesis is part of a PhD-project run by Emine Kale, Specialist in Clinical Psychology at NAKMI (Nasjonal kompetanseenshet for minoritetshelse), focusing on patients’ expressions of emotional distress. My study is intended to be a base for comparison of findings in Kale’s project, but can also exist as an independent piece of work. Much of my work has been taking place at NAKMI, where my data was kept in compliance with regulations.

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Abstract

This thesis investigates interactions observed when patients are not understood in intercultural medical consultations, and further how emotions can be interpreted from these interactions. More knowledge and understanding around minority health is needed as Norway faces challenges in minority health related issues, and doctor-patient communication is highlighted as a specific area of focus. Interpersonal and institutional communication is essential for successful social integration and well-being for individuals, and the recognition and understanding of emotional distress is considered to be a central component of this development. Twelve videotaped medical consultations with six ethnic minority patients and six ethnic Norwegian patients were transcribed and analyzed employing discursive and conversation analytic approaches. This methodological approach was intended to offer a new cultural perspective to earlier findings on the topic. The analysis and results support earlier findings, and has further identified distinct sequences of interaction in doctor-patient communication when patient did not seem understood. These interactions consist of practices around justification, building alliance, rhetorical reasoning, and direct arguing, in addition to some features observed in situations where understanding seemed to be attained. The main findings show that patient concerns and emotional distress are often expressed through indirect expressions as to downplay concerns and worries.

Key words: ethnic minorities, medical communication, emotion, discourse analysis
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Introduction

“Minority health is one of the true large challenges we have to prioritize in the coming years” proclaimed Bjørn Guldvog, constituted director at Directorate of Health in a recent news article (Bakken, 2011). The article revealed an appalling gap between ethnic minorities and ethnic Norwegians health conditions, and called attention to how ethnic minorities are overrepresented for illnesses such as; diabetes, Vitamin D deficiency, obesity, and gestational diabetes. In November 2010, a media headline announced “Minorities more often to Oslo Emergency Room (Sahl, 2010). The article described a trend where minority patients were more likely to visit the emergency room instead of consulting their general practitioner (GP). A Lithuanian patient interviewed in the article put it in bluntly: “I would rather wait three hours here, than to waste my time seeing a doctor who is not able to give me the help I need”. Both articles point to communicative challenges between minority patients and Norwegian doctors as the primary concern.

Medical doctors by trade experience a vast range of demands through their daily work in patient interaction. And in addition to the demands of patient interaction, physicians are continually challenged to balance the further demands from society and patients concerns (Nilsen, 2010). Unsurprisingly, doctors and patients can perceive a consultation very differently based on varying communicative expectations and preferences. Logically, these factors may influence the development of patients’ trust; the basis for achieving common understanding and health cooperation (Pasientombudet.no, 2010). It is therefore not a surprise that many patients find this relationship difficult. Last year, Norwegian assigned GP (doctors part of the Registered General Practitioner Scheme) were given a below-average score for patient communication, availability and time spent with each patient, based on the patients’ responses to The 2010 Commonwealth Fund survey (Eike, Forsetlund & Kirkehei, 2010). For ethnic minority patients facing language and cultural barriers the medical encounter may be additionally challenging. As the blend of cultures continues developing and becoming increasingly complex, so does the need for communicative tools required by medical doctors and health providers. In order to better understand patients’ needs and concerns, intercultural awareness and competence is essential.

A range of both quantitative and qualitative studies on patient’s responses and communication in medical settings has been completed. Still there seems to be less research
tied to intercultural differences (Zimmermann, Piccolo & Finset, 2007). The majority of studies where cultural differences have been evaluated have been completed in the United States during the last decade and mainly developed by quantitative methods (Schouten & Meeuwesen, 2006). More qualitative methods and observational analyses have been desired in order to gain greater understanding in intercultural medical communication (Marcinowicz, Grebowski & Chlabicz, 2009; Shouten & Meeuwesen, 2006). A Norwegian study on intercultural challenges of general practitioners and migrant patients also suggested participant observation as a method to reveal more information about doctor and patient communication (Småland Goth, Berg & Akman, 2010). Further the focus on understanding patients’ dissatisfaction and patient-centeredness in inter-ethnic and cross-cultural settings has been desirable, as it will provide information on how to improve the doctor-patient relationship and other health care relations (Lo, 2010; Marcinowicz et al., 2009).

My aspiration for this study is to contribute to recognition, understanding and consideration around minority patients’ needs and concerns. My focus will therefore be on doctor-patient interaction in intercultural consultations between doctors (both Norwegian and non-Norwegian) and patients (ethnic minorities and Norwegians). This research is guided by the following questions: what kinds of interactions can be observed when the patient does not seem understood in intercultural medical consultations? And what can be interpreted as the emotional content of those interactions?

I will start by looking at some background factors to illustrate the underlying connections within this topic such as the intercultural situation in Norway, individual and social functioning, cultural characteristics in medical communication, intercultural challenges, the functions of emotions, emotional expressions in medical consultations, and finally I will discuss the focus of my study.

**Norway a Multicultural Society**

Oslo is currently the fastest growing capitol in Europe (Hagesæther, 2011). Norway along with other countries is hence experiencing a continuous influence from new and distant cultures. The highest concentration of immigrant proportion in Norway exists in Oslo, where roughly one quarter of the population consists of first and second generation immigrants (Statistisk sentralbyrå, 2011). The immigration curve escalated particularly during the last decade, peaking between 2006 and 2009. More than half of all immigrants in Norway come from Asia, Africa and Latin-America, with Pakistan, Iraq and Vietnam as the three most represented countries within this group (Statistisk sentralbyrå, 2011). This trend produces
opportunities, along with a continuing need for knowledge and understanding about how we interrelate and communicate with each other as individuals, groups and social systems.

**Individual and Social Functioning**

In order to facilitate and arrange for individual and social functioning we need to understand the process of immersion into a foreign culture. The immigration process can be stressful and demanding for the individual (Lazarus, 1997). While trying to handle diverse cultural identities, migrants may experience different levels of intrapersonal identity conflicts. For instance, if the individual continuously feels excluded, the likelihood exists of the immigrant to develop ambivalent or marginal identity, instead of the healthier multicultural identity (Berry, 1997). Berry (1997) has presented an acculturation framework for the immigration process, with four possible outcomes for the individual: assimilation, separation, integration and marginalization. Integration is the desired outcome and the only outcome where the immigrants experience the process to be voluntary and the majority group and dominant society to be inclusive and open. By having supportive relationships and by participating in national institutions (as education, work, and health care) to a desired extent, the individual will better adjust to a new situation and will be more likely to reduce stress associated with separation (Berry, 1997).

I believe that in learning more about interpersonal communication between an individual and one of our social systems, this knowledge can strengthen awareness of institutional communication in other areas, be transferred and applied across situations and disciplines, and in the end better assist the individual in adjusting and adapting to our society in a more optimal way. The medical field appears large and complex, and the communication between doctor and patient deals with issues and challenges that looks to be representative for much interpersonal and institutional communication in general, such as for example imbalanced and asymmetrical power relations, the need of self-disclosure and openness, and situational stressors like scheduled meetings and limited time.

I will now take a closer look at some characteristics of medical communication.

**Culture in Medical Communication**

Good communication and positive health outcomes are associated (Ali, Atkin & Neal, 2006). Patients in general are shown to put a high value on the factors of not being rushed (higher than length of the consultation) and visiting a doctor who displays good interpersonal skills (Steine, Finset & Lærum, 2000). Our behavior and communication is influenced by our social values and perceptions (Ashton et al., 2003). These social values and perceptions are
“product of national culture, racial and ethnic culture, gender culture, occupational and professional culture, education and knowledge, social class, religious beliefs, and personality traits” (Ashton et al., 2003, p.148) and influence how we explain the actions around us, and therefore constitute our explanatory models. These models can be thought of as the key to understanding between the doctor and the patient, and a tool to develop congruence, which yet again is dependent on the effectiveness of the communication and how the two parts manage to elicit information from each other (Ashton et al., 2003). Since cultural and social experiences influence the patients’ and doctors’ beliefs, expectations and attitudes in medical interactions also will be different (Perloff, Bonder, Ray, Ray & Siminoff, 2006). Thus, despite having honorable intentions, unrealistic assumptions and biased attitudes are likely to exist, from both the doctors’ and the patients’ side (van Ryn & Burke, 2000).

Hofstede (1983) defines four dimensions of national cultures that influence interpretation and understanding of our surroundings; power distance, uncertainty avoidance, individualism and masculinity. These dimensions are often used in explaining different psychological issues in a cultural context such as anxiety, aggression, stress and assertiveness (Hofstede, 1983). Especially in cultural research the dimension collectivistic-individualistic is frequently referred to. Ethnic minority patients have been found to for example show more collectivistic values (communal or family interest higher than interest of individual), suppression (afraid of asking questions and appear stupid), skepticism (suspicious of medical research) and the seeking of alternatives (look to other people for advice) (Sharf & Kahler, 1996). The physicians, on the other hand, were more inclined to show individualistic interest, believe questions and interest to go together (questions reflect patients’ interests for knowledge), work research based (use clinical knowledge), emphasize their medical expertise (resign from home remedies), and be in charge of the consultation (physicians in control of medical management) (Sharf and Kahler, 1996). Factors specifically tied to influence minority patients’ medical communication in Norway has been recognized to be; level of education, extent of similarity to health system in the country of origin, length of residence in Norway and cause of migration (Småland Goth et al., 2010). Consequential challenges appear when doctors and patients work with different explanatory models.

**Intercultural Challenges**

*Language and dialect discordance* is one of the most obvious challenges to productive communication, and is highly central for mutual understanding between two people (Rawls, 2000). If the doctor and the patient use dissimilar terminology in explaining a problem, or
have different linguistic cultures, this alone is enough to have a negative influence on the communication (Ashton et al., 2003). Disclosure of information is another challenge. Perloff et al. (2006) found that interaction during the primary care interview and type of information given is a critical area for communication mismatch (Perloff et al., 2006). In an American study on underlying expectations in conversations between those who self-identified as Blacks and Whites, it was found that African Americans preferred to differentiated public and private information, and therefore tended to choose a communication style that focused on personhood and egalitarianism, or talk about the immediate context, as opposed to Whites who valued sharing information about social categories, so called categorical talk (Rawls, 2000). A possible explanation could be that the African Americans do not feel comfortable to disclose information about each other’s social hierarchies (Rawls, 2000). Participation is also influenced when different explanatory models are used. An American study found that African Americans rated their medical visits less participatory than Whites (Ashton et al., 2003, p. 149). The same pattern was found with Korean-Americans and Mexican-Americans, who showed less active participation in decision-making for information disclosure than White Americans (Schouten & Meeuwesen, 2006). Doctors were also found to display less affection while communicating with ethnic minority patients compared to whites (Schouten & Meeuwesen, 2006). One assumption made by many doctors is that patients prefer to be involved in their own care (Schouten & Meeuwesen, 2006), and further doctors have expressed a preference for these patients who consider themselves to be contributors to their own health (Småland Goth et al, 2010). Friendly talk (or small talk) has been considered a challenge. Several indicators show that ethnic minority patients have found it difficult to express concerns and engage in social conversation in a medical consultation environment (Schouten & Meeuwesen, 2006). Friendly talk may seem redundant, but when incorporated this may promote to understand the person as a whole. The concept of storytelling, learning about a patients’ story and plotting patients’ information in a narrative, might be a way of negotiating diverse explanatory models and further bridge cross-cultural understanding (Lo, 2010). Empathy is recognized as detection and reflections of the patient’s feelings, versus sympathy can be seen as a parallel reaction to emotion (Frankel, 1995). Empathic communication has also been found to negotiate explanatory models as doctors’ empathy is associated to have a strong positive influence on patient satisfaction and loyalty to treatment plan (Frankel, 1995).

How can we learn to minimize the challenges explanatory models bring? Going back to Berry’s acculturation framework for the immigration process, Lazarus (1997) interprets
Berry’s frame to be structured and static, and suggests a more flexible and individually process-centered approach. He puts a stronger emphasis on adaptational tasks, family situation, moving and location, and the fact that acculturation can take place in a wide range of different situations – even within one’s own culture. In the same way as Lazarus suggests a wider perspective on understanding acculturation, he also suggests a stronger focus on emotions as he believes emotions offer a rich and clinically useful expressive and systematic focus to cultural understanding (Lazarus 1997). Learning more about patients’ emotions may take us a step further into discerning and understanding patients concerns.

**Functions of Emotions**

The study of emotions is a vast area within the psychological field. An emotion can been described as a “relatively intense feeling characterized by physiological arousal and complex cognitions” (Kenrick, Neuberg and Cialdini, 1999, p. 43). Traditionally the most basic-level emotions have been considered to be; love, joy, surprise, anger, sadness and fear, with connecting subordinate-level emotions and emotional blends (Parrot, 2001).

Our emotions are culturally dependent because our culture teaches us when and how it’s appropriate to experience and express emotions, and how they are supposed to be recognized (Chiu & Hong, 2006). This makes emotions difficult to translate and interpret across cultures (Malik, 2000). Thus, all aspects of emotions need to be studied cross-culturally, and researchers need to be aware of communication, assumptions and vocabulary used in these studies (Wierzbicka, 1999). Further, our emotions are social in the sense that they influence our thoughts and behavior, and how we interpret, connect and function with those around us (Parrot, 2001). Emotions therefore enable us to recognize what’s important to us, enjoy life, send signals to those around us, and help us make the right decisions (Denollet, Nyklicek and Vingerhoets, 2008). Naturally, different cultural practices influence how our emotions are socially interpreted. Collectivistic cultures based on interdependent values show for example a tendency towards self-harmonizing effect and concerns regarding social belonging, which again relates to how positive emotions are connected to relationships and the presence of others (Markus & Kitayama, 2001). Contrary, the false uniqueness effect, the well-documented tendency to feel positively different from others, is more common in an individual cultural frame, where selfhood, uniqueness and autonomy are considered of high value (Markus & Kitayama, 2001).
Emotional Expressions in Medical Communication

Why is recognition of emotions important in medical communication? When doctors understand patients’ concerns, worries and dissatisfaction it is easier to provide the precise kind of information and help (Marcinowicz et al., 2009). In order to be able to understand and learn more about patients’ concerns we have to learn more about how emotional distress is expressed (Zimmermann et al., 2007).

There has been a discomfort associated with expressing negative emotions or emotional distress. One participant in a Polish study stated: “I feel better when I say good, positive things, but when I have to speak about negative things I feel bad” (Marcinowicz et al., 2009, p. 189). As a consequence patients often use adaptive strategies to avoid direct negative expressions (Marcinowicz et al. 2009). Laughter is an example of one such strategy, as it has among other functions been shown to downplay concerns (Kovarsky, Curran, Nichols, 2009). Further, body language has been recognized to be prominent in expressing negative emotions. In a study where facial, body and vocal expressions were manipulated, facial and bodily expressions tended to show the strongest association with a specific emotion (especially anger and sadness), whereas vocal expression showed a slight weaker association with a given emotion (especially anger and happiness) (Flack, 2006). Pattern of for sadness could for example recognized as relaxed eyebrows, lower lip pushing up, and dropped head and rib cage (Flack, 2006).

Some reasons around the discomfort of expressing negative emotions have been related to the fear that negative utterances can have a negative effect on further medical care and lack of faith in that expression of opinions may change for the better (Marcinowicz et al., 2009). Still the release of negative thoughts is considered to be a relief for the patient. In going back to Marcinowicz’s study, another participant stated: “I feel better now that I have expressed all these grudges. You can feel better when you have been heard” (Marcinowicz et al., 2009, p. 192). This is especially essential with anxious patients as they tend to concentrate more on their worries than on the doctors’ health messages (Bensing, Verheul & Dumen, 2008). Individuals who do not suppress emotions are in general found to experience more positive and less negative emotions, higher scores of happiness and lower scores on depression, better social support, self-esteem and well-being (Matsumoto, Yoo, & Nakagawa, 2008).

How does culture affect this associated discomfort of expressing negative concerns? In returning to Hofstedes the dimensions of national cultures, it is found that cultures high in power distance, uncertainty avoidance and collectivism are all associated with the rejections of negative emotions (Fernández, Carrera, Sánchez, Paez, & Candila, 2000). In these cases
negative emotions are often expressed in an indirect manner, as for example by being polite and being indirect. (Fernández et al., 2000). Novin, Rieffe and Mo (2010) conducted a study on how situational goals and audience influence a person’s emotional experience and expression. Their study, on Dutch and South Korean children, showed that whether or not the children experienced negative emotions appeared to be similar between the two groups, whereas how their emotions were expressed seemed to vary depending on the audience (presence of father versus presence of peer) and the situational goal (collectivistic or individualistic) (Novin, Rieffe & Mo, 2010). The study illustrates two important factors related to cultural models of emotions; the value of situational goals and the significance of hierarchy and authority. The tool of using rhetorical tricks was further seen in a Polish study on the expressing of dissatisfaction (Marcinowicz et al., 2009).

The ability to recognize and reflect on own emotions and emphasize with others emotions is important in maintaining good quality interpersonal relationships (Ozcelik & Paprika, 2010). Clinical treatment has thus been encouraged to “more explicitly aim at enhancing self-regulation and emotional regulation” (Denollet et al, 2008, p. 8).

**The Focus of this Study**

Based on our knowledge on cultural challenges in the Norwegian society, individual and social functioning, the use of explanatory models, intercultural challenges in medical communication, and the importance of emotional expressions and concerns, I wanted to investigate how patients actually do express concerns, worries and other negative emotions in intercultural medical consultations in Norway. To define a frame for how to study negative emotions, I decided to focus on situations where patients do not seem to be understood.

Although Paul L. Harris writes about children and emotions, his characterization of seeing humans as “born with the capacity to experience basic emotions of sadness, anger and joy when desirable goals are lost or blocked or achieved” (Harris, 1989, p. 103) directed me towards this particular situation. Therefore, my assumption is that the feeling of not being understood is linked to a whether or not a goal is being blocked, or perceived being blocked, and that this feeling trigger the experience of negative emotions (Ben-Zeév, 2010).

In an attempt to address the different issues discussed above, I have two questions guiding my research: what kinds of interactions can be observed when the patient does not seem to be understood in intercultural medical consultations? And what can be interpreted as the emotional content of those interactions?
**Method**

I will in this section give a compressed background for my project and how I gained access to my data, my epistemological, methodological and theoretical positioning, the development of field notes and transcripts, and data analysis.

**Project Background**

I learned that the medical field may appear less accessible and more difficult to study than many other areas. Entrance to the field requires adequate time for applications, ethical approvals, and practical arrangements, interest, understanding and approval from a medical institution (often through contacts), doctors’ and patients’ acceptance and consent to participation, sufficient video and audio equipment (in case of naturally occurring exchanges) and a system for saving and preserving sensitive and confidential data. Given the limited time frame of one academic year estimated for my project, this approach would not have been realistic if I had not been given the opportunity to join a presently active project.

The project I joined is a PhD-project run by Emine Kale, Specialist in Clinical Psychology at NAKMI (Nasjonal kompetanseenhet for minoritetshelse), Oslo Universitetssykehus, Ullevål in Oslo, which is focusing on patients’ expressions of emotional distress, which are defined as cues and concerns, during medical consultations. Emine Kale has, as one part of her PhD-project, coded a large number of videotaped medical consultations collected at the Akershus University Hospital. The consultations consist of interactions between patients with different cultural and ethnic backgrounds and doctors with Norwegian background (and a few with other European background). The coding has been done according to a quantitative method using Verona Coding Definitions of Emotional Sequences (VR-CoDES) and the Verona Codes for Provider Responses (Verona Codes-P), specifically developed to capture patients’ utterance of emotional distress and health provider responses to these. In my study I transcribed and analyzed selected consultations from Kale’s sample using a qualitative methodology. Even though I have a different focus in my study my results can be a base for comparison and verification of the earlier findings in Kale’s study. The comparison of results will be completed and published at a later time and will therefore not be included as part of my study. This present study exists as an independent and adequate piece of work.

I feel privileged having been able to take part of this groundbreaking research, first time performed in Norway.
Data and Participants

The original database in Kale’s study consisted of 56 video recorded interactions with 26 physicians. The data is collected at Akershus University Hospital in 2007 and 2008 as part of another communication project: “The Four Habits Approach to Effective Clinical Communication” study. The sample included all patients with a variety of cultural backgrounds as Eastern Europe, The Middle East, South America and South Asia, or born in Norway with two immigrant patients. The specialists had mainly Norwegian background, but a few had other Scandinavian or Western European backgrounds. Encounters included first time and follow-up outpatient and bedside meetings in general internal medicine, orthopaedics, gynaecology, cardiology, and paediatrics.

In beginning the analysis we sampled 12 pre-selected videotaped consultations to analyze. The information I received about the videos was that 6 out of 12 had been coded to contain patients’ expression of emotional concerns, and that the remaining 6 had been coded not to contain this (based on the VR-CoDES coding). Further, I was told that each set of the 6 videos consisted of 3 videos with ethnic Norwegian patients and 3 videos with ethnic minority patients. I did not receive any prior information which videos belonged to which category (which of these had been coded beforehand containing emotional concerns) or which contained patients with Norwegian or ethnic minority background. Further, I had no existing knowledge or information about the participants whatsoever (cultural or ethnic background, personal demographics, medical history or background for their visit) or how and why these particular consultations had been selected for me to analyze. Hence, I had to utilize my personal interpretation for any assumption regarding cultural background of patient, age and a possible previous relationship between the doctor and patient.

The participants are mainly referred to as patients and doctors in this study. Patients are either defined as ethnic minority patients or ethnic Norwegian patients, since they all may formally be Norwegian citizens. American Psychological Association Publication Manual suggests the researcher using a modifier such as ethnic in front of minority, and in general to be sensitive and as specific as possible when referring to groups of individuals (American Psychological Association, 2009). For the doctors that sounded to possess a linguistic accent I have decided to use the concept of “foreign background”. In the consultations involving small children (two consultations) the adult carrying the main conversation with the doctor is portrayed as the patient, since the intent of my study is focusing on adult institutional communication.
The 12 consultations lasted from 8 minutes to 57, with an average of 30 minutes. The camera was positioned in various angles in the different doctors’ offices and check up rooms and gave at the least a full view of the doctor. The patients were seen from different angles, but mostly from the side and often from behind. This made it challenging to see facial expressions or faces gesticulations. (In one consultation the camera was focused on a corner of the room and no participants were visible.)

Through the ethical procedures/agreements of the PhD-projects, all participants have given written consent for use of the videos for research purposes, and the participants have had full protection in regards to handling of personal data, anonymity and ethical conduct. My work has undertaken the identical conditions as the PhD-project. Out of this concern, I only have had access to work with the data NAKMI, where the data has been kept in compliance with the regulations (numbered Windows Media Video files on a separate encrypted hard disk). My participation and work was approved by the Regional Committee for Medical Research Ethics, South-Eastern Norway.

**Epistemology**

My aim for this study was to understand the interaction processes where emotions were involved in cross cultural medical consultations between doctors and patients. I did not expect to find (and hence did not look for) a single truth or a key solution in understanding patient’s expression of emotions, but this rather to be dependent on the social setting, interaction and communication between the two parties involved. My epistemological assumption is therefore that knowledge will be tied to the process around how a patient expresses emotional concerns. This knowledge can be found through the patient’s verbal and nonverbal communication; how a message is delivered and perceived and how the exchange of information proceeds between the doctor and the patient.

**Social constructionism.** My epistemological approach is based on social constructionism, an approach that reads and understands a situation based on the social context and by its social function, and uses language and the hermeneutical processes as central for this understanding (Guba & Lincoln, 1994; Willig, 2007). By interpreting the observed reality as dependent on people’s beliefs and understanding, individually and/or socially constructed, I have contrasted the positivistic and traditional psychological view and taken an *idealistic* approach (Griffin, 2000). I am open for the fact that several “knowledges” can exist, and see my goal as to locate associations between my research question and topic focus (Willig, 2007).
In observing a naturally occurring situation I define myself an ethnographic researcher. I have searched to understand a complex issue, and been open to and aware of a variety of perspectives. Ethnographic methods have come to present a distinct and important contribution to research with interest in cultural practices, since the researcher observes and understands the participants from a self-understanding perspective (Griffin, 2000). Shweder (1997) has criticized psychologists with the traditional Anglo-American background by the fact that they not only have used experimental and cognitive practices, but also cultural and universal assumptions while doing intercultural research (Shweder, 1997). Shweder therefore emphasized the importance of being open for discovering; making room for creativity and disciplined intuition, and warned us to look for something that is not there:

“It is about entering the field without totally predefining the domain of interest and without presuming that you already know what is universal, because most of the time those universals are generated out of one’s own perspective-dependent, context-dependent and hence local world.” (Shweder, 1997, p. 154)

**Reflexivity.** In studies involving ethnic minorities it is especially important to let the participants speak for themselves and to see the situation through their eyes. Ethnicity and culture are socially constructed terms made up of our assumptions, which makes this knowledge subjective and culturally biased (Kamenou, 2007). From this viewpoint, one can say that the researcher and the social world influence each other, and that the researcher produces findings (Mauthner & Doucet, 2003; Spencer, Ritchie and O’Connor, 2006). This is why reflexivity, reflection of one’s own subjective position, is so central and important for the validity and credibility of ethnographic studies and qualitative studies in general (Mauthner & Doucet, 2003; Potter & Wetherell, 1987). Reflexivity should therefore be an open and continuous process, operationalized and included as a part of the data analysis, where issues like linguistic and rhetorical strategies, social and personal location and perspectives should be accounted for (Mauthner & Doucet, 2003). A way for the researcher to account for reflexivity is to search to study the findings from the participant’s standpoint, influenced by him or herself as an observer. For the present study this could be to ask questions such as: can emotions have different meanings for the doctor and the patient, be expressed differently depending on the patient’s ethnic and cultural background, be influenced by situational aspects, medical history and personal experiences, elicit different reactions based on the receiver, and be interpreted differently based on who is performing the observations? How will I as a white middle-aged ethnic Norwegian woman, with an educational background in psychology, no work experience in the medical field, and little direct experience with
different cultures or ethnic minorities interpret the consultations and influence my findings? For example; will my expectations of the doctor, as not always being sensitive towards minority patients, make me a biased observer? Will my limited knowledge from the medical field put me at risk of omitting out on essential parts of the consultations? Will my limited experience with non-western cultures enable me to overemphasize “normal” utterances as concerns, and overlooking others? I expect my interpretation to organically change/alter throughout the process, as I study, revise and process my data. Even though ethnography is considered as participated research, there are examples of more limited forms, like in this case where I have taken a none-involved but observational role (Griffin, 2000).

Ethics
Through my work I will provide a voice on behalf of a group of people and their reality (Cieurzo & Keitel, 1999). Since I will use data material that has already been gathered, I will not myself be involved in recruiting or informing participants. On the other hand, I will be responsible for treating the data material and information obtained from the videos with care. Even though I take ethical precautions in regards to permissions, rules and agreements, I still have a responsibility to produce research that is of good quality, has a defined purpose and is seen as “legitimate public concerns” (Mason, J., 2002, p. 202). I will be aware of the balance in producing data that serve a purpose for broader societal interest and the subject group and for “stakeholders in my immediate research environment (Mason, J., 2002,). Cieurzo and Keitel (1999) has three reminders which I will carry with me as I proceed with my project; to be sensitive to the experiences of those I study, not to compromise the well-being of the participants, and to structure my research in such a way that the participants will benefit from it (Cieurzo & Keitel, 1999).

Methodology
Ethnomethodology is the study of ordinary people’s methods, and how people use these methods to build and shape their social life (Potter & Wetherell, 1987; Silverman, 2006). In taking an ethnomethodological approach I have focused my attention to observable details, but unlike in naturalistic fields, my observations have been limited to talk-in-interaction (Silverman, 2006). My intention has been to; discover findings that will help us learn how the participants understand themselves and their environmental status. My interest has been to discover trends, patterns, sequences, implication and consequences that have made the communication process meaningful, interesting, comprehensible and further predictable in recognizing and interpreting the expression of emotions. My interest therefore has been
mainly concerned with how emotions are expressed and what kinds of emotions are seen, rather than why emotions were being expressed.

Based on my data, research question and epistemological position I have taken a qualitative methodological positioning and used discourse analysis as my theoretical framework. Culture and the context influence how a person understands him or herself, and discourses serve as particular interpretations of the individual in social or interpersonal situations:

“There is not ‘one’ self waiting to be discovered or uncovered but a multitude of selves found in the different kinds of linguistic practices articulated now, in the past, historically and cross-culturally.” (Potter & Wetherell, 1987, p. 102)

The main focus of discourse analysis is to study what talk can do for the individual as medium for action (Potter & Wetherell, 1987), in other words how language is performative and used to construct social life (Rapley, 2007; Willig, 2007). This theoretical positioning is in strong contrast to the traditional psychological positivist view, where talk is a reflection of a person’s inner and unambiguous mental state and understanding of external world (Nelson & Prilliltensky, 2005; Willig, 2007). One can therefore conclude that discourse analysis is the opposite of, and also based on a critique towards, cognitivism and objective perception, and has accordingly influenced the shift from the individual and innate intention to the intention of language and the potential of its use (Willig, 2007).

There are different traditions within the theory of discourse analysis, and the structure and terms may be intertwined and hard to distinguish. I chose the direction of discursive psychology for my study.

Discursive psychology is a term composed of conversation analysis, ethnomethodology and discourse analysis, and offers in depth analysis of action oriented talk, either spoken or written in text (Griffin, 2000). This view argues that in order to derive meaning of what is being said, the social context, attitudes and goal (social objectives) of the conversation have to be taken into account. It looks at the performative qualities of discourse; how something is being said and for what purpose (Willig, 2007; Potter & Wetherell, 1987). Silverman (2006) juxtaposes conversation analysis and discourse analysis, both covered under the umbrella of discursive psychology, in that these are both two theories for analyzing talk in written forms. Silverman further differentiates the two; he states conversation analysis (CA) to be a branch deriving from ethnomethodology, with a focus on the methods for producing orderly social interactions, like sequence, turn taking and the organization of a conversation. Discourse
analysis (DA), which is a branch deriving from constructionism, Silverman considers to have more in common with social science perspectives such as; gender, social control and identities in connection to talk and language. CA, thus focuses specifically on the sequence of dyadic conversations (mainly in transcripts), while DA is open to include broader data (e.g. interviews, field notes or documents). One can therefore deduce that CA has a stronger focus on details and structure and is thus more conventionally methodological robust. Whereas, DA, has a stronger influence stemming from sociology and therefore has adopted a further relativist position (Silverman, 2006).

Discourse analysis takes an inductive position to generating knowledge; implying that rather than analyzing data to test a hypothesis, the tendency is to use the data to generate a hypothesis (Silverman, 2006). This brings us back to Shweder’s emphasis to remain open for discovering; we have some ideas and background knowledge about the topic, but yet need to be vigilant in our approach to the data as open, humble and with a curious mind (Shweder, 1997). Hopefully, in turn our attentiveness will result in new and unexpected discoveries.

**Discursive Psychology**

In using discursive psychology to gain knowledge and understanding around how patients construct their talk and how they express emotions, conversation analysis and discourse analysis will give me different perspectives and angles of the topic.

By using CA I can look for specific patterns in the conversation flow and learn more about, for example: how exactly is an emotional concern expressed and how does this have an effect on the situation, for the patient and for the doctor? How can an emotional concern be recognized, and how is this responded to by the doctor? By taking a narrower focus and more detailed approach, conversation analysis offers a rich description in interaction as well as a solid explanation of institutional interaction (Rapley, 2007). The context will be deemed as relevant if the participants make use of their institutional or professional identities. This depends on the participants’ orientation and how far this has a consequence for the talk (Silverman, 2006).

By taking a broader perspective and utilizing DA, the other division of discursive psychology, this direction may help us understand broader issues such as: how are the participant’s cultural identities confirmed and verified through expressions of emotional concerns? How can we understand the inner psychological world through their use of discourse and language? Why do the participants construct and shape statements the way they do in the consultations? There are different ways of interpreting these repertoires as for
example through hyphenated phenomenon (how aspect have different meanings in different contexts), stakes (referential social categories) and scripts (routine of approved or disapproved events) (Silverman, 2006). By taking this perspective context will be more prominent, since DA is less influenced by ‘paradigms’ as compared to CA.

Both CA and DA will thus give essential data relevant for my research question. On one hand CA may seem like the most appropriate. To begin with, I believe that learning more about how the sequence and flow of the conversation actually does influence talk, and especially viewed from a cultural perspective, will give interesting and valuable information to my research question. Secondly, this study has the proper setting for a detailed focus; videotaped dyadic medical communication. Thirdly, this theoretical angle has a strong and solid methodological foundation, which may appear more specific and guiding for my research. I see two challenges in choosing this direction; one that I may not (out of practical reasons) manage to get sufficient detailed transcriptions and two that I may miss out on important overlaying sociological and broader concerns. The reason for choosing DA, the other division, is that I have a topic that is interesting to pursue also from a broader perspective. Secondly, in taking a broader perspective I perceive DA to be most appropriate dealing with intercultural studies. Thirdly, I support the reflexivity assumption that is strongly implied here. My challenges here lie mainly around the methodological guidelines being less specific, and that the patterns and result may be more vague and subtle to discover and explain.

In finding both CA and DA relevant and essential; I decided to use analytical principles from both of these theoretical frameworks. The gap between the analytical perspectives have minimized over time, and it has become more prevalent to combine the two (Silverman, 2006; Potter & Wetherell, 1987). I will now explain how I handled my data in order to account for both analyses.

Data in Written Formats

My data consisted of 12 videotaped consultations of dyadic conversations between doctors and patients. Since I planned to make use of theoretical structures from both CA and DA in my analysis, I decided to transform my data into field notes and transcripts.

Fieldnotes. Observational studies like fieldnotes or extended transcripts, might help the researcher create instincts and intuitions which may not be obtainable from transcripts alone (Silverman, 2006). Such observations can be helpful in order to understand the participants’ perspectives and cultural practices. An unforeseen setback is to produce observational notes
which report ‘everything’ and end up accumulating too much data. One way to keep a narrow
and relevant focus is to have specific questions in mind when making field notes (Silverman,
2006). My questions were the following:

1. *Where do I perceive the patient not to be understood?*
2. *Are there emotions to be interpreted in these sequences?*
3. *What does the patient want to accomplish?*
4. *Which assumptions are made (by the patient, the doctor and me as the researcher)?*
5. *How is language used?*
6. *What did I learn from these notes?*

The two first questions are a direct reflection of my research question. The third and fourth
questions were meant to help me open up for a broader reflection and consideration, and to
understand where origins of this reflection. The fifth question was included for my own
awareness; so as not to transmit and ‘reduce’ social life according to the definitions and
understandings of the participants themselves, but to keep focus on what people actually were
saying and doing (Silverman, 2006). The fifth question was to aid in summarizing my
impressions.

I started to take fieldnotes immediately as I started watching a videotaped consultation. I
did because, I wanted to capture and maintain my first impressions, as I gradually would
become more and more familiar and adapted to details and nuances. I did the first part of my
fieldnotes during my first observation, leaving a second part open for impressions, thoughts
and reflections while producing my transcripts.

**Transcripts.** After completing the first part of my fieldnotes from one doctor-patient
consultation, I started transcribing that very same consultation. I aimed for a transcript with
the ‘right’ level of details in reflection of, and in regards to my research question and the
planned analysis (Flick, 2002). Detailed analysis like CA requires a rather detailed transcript,
and the Jeffersonian model is the most frequent script recommended (Rapley, 2007). Poland’s
instruction for transcribers is less time consuming and technical, but is still “far from the
simplest level of transcript” (Rapley, 2007, p. 60). Out of practical concerns (time and
experience) and the fact that I planned a combined analysis of CA and DA, I decided to use
the guidelines of Poland, together with my own additions of nonverbal behavior. Nonverbal
features were included as separate lines in my transcript. (See transcription guidelines in
Appendix A.)
The transcription was completed without using analysis software, but by simply using Word documents from Microsoft Office, saved as doc. files. I found that producing the data this way gave me a sense of closeness to the data.

The videotaped consultations lasted for 6 hours and 5 minutes, and resulted in 178 pages of transcripts. The physical act of performing the actual transcription became a very useful process since it took me further into the details and nuances of my material and gave me a steady start with discovering patterns and concepts (which I further debated and considered in the second part of my fieldnotes). Working with tapes and transcripts does have the advantage in the availability of format, that the tapes can be replayed and transcript can be improved, and that the researcher is free to inspect utterances he or she finds interesting independent of other research (Silverman, 2006).

I attempted to transcribe as close to the oral pronunciations as possible, basing my language form on “bokmål”. Where the participants used a personal touch or shape of a word I included this for example as, “feber’n”, “frysi”, “morran” (as opposed to the correct lettering “feberen”, “frosset”, “morgenen”). I have included prefaces like “ah”, “mhm” and “mmm” as close to the pronunciation as possible. I started my sentences with a capital letter in the first word, but otherwise used lowercase letters elsewhere, leaving the capital letters for utterances with emphasis. I used commas where this helped explain the meaning of a sentence. The excerpts used as part of my analysis were translated to English. In the incidences of broken Norwegian, this became challenging to transfer to English as the content sometimes seemed to be lost in translation. Based on this, and for accurate documentation, all excerpts used in this paper are found in its original form in the appendix (Appendix B). The nonverbal language turned out to be more of a challenge to transcribe. Even though I used my research question as my guideline, the level of details became difficult to determine. I aimed to focus mainly on eye contact, positioning and body posture since I found this relevant for the parts where emotions were apparent (Flack, 2006).

I went through the tapes twice after completing the first round of transcription, to ensure that the essentials were captured and data coherent.

**Conducting my Analysis**

In carrying out my discourse analysis I have followed Carla Willig’s (2007) guiding principles for utilizing discursive psychology and Tim Rapley’s (2007) access points to analyze the conversations.
Carla Willig’s (2007) procedure for doing discursive psychology consists of four main steps: reading, coding, analysis and writing (Willig, 2007). Willig underlines the importance of going beyond the understanding of content and discover the action orientation – the orientation that should guide our analytic work. In her first step, reading, she stresses the importance of reading all the transcripts before starting the analysis, since this practice will help us observe the larger picture of “what the text is doing” (Willig, 2007, p. 165). As a second step, coding is done in light of the research question. Willig stresses that all relevant constructions and connections should be included, instead of simplifying by using keywords. The particular sections of interest in a transcript should be marked, copied and categorized for analysis. The third step, analysis, is the step where the reader interacts with the text, meaning that this is where the reader looks for functional and constructive dimensions of the communication. Willig suggests the reader should have specific analytical questions in mind. My questions were:

1. **Where in the consultation do I get the sense that the patient is not understood and that there is an emotional reaction in these sequences?**
2. **How do I see this emotion expressed by the patient?**
3. **Which emotions do I see?**
4. **How and why does the patient not seem to be understood?**

In order to produce a systematic and persistent exploration Willig suggests to the reader to pay attention to the use of different repertoires, terminology, stylistic and grammatical features, preferred metaphors and other figures of speech (Willig, 2007). Through these repertoires the researcher should try to identify the action orientation and the consequences for the participants in the conversation, a goal only possible through focusing on language in context. “The analytic focus should be upon the variability across contexts and the action orientation of talk.” (Willig, 2007, p. 166). The fourth step writing Willig explains to be part of the analysis itself, as this process will enlighten inconsistencies and tension which may lead to new discoveries.

Tim Rapley’s (2007) encourages us to explore conversations by taking notice of the common ‘taken-for-granted’ ways we naturally use when interacting (Rapley, 2007). He encourages us to look for access points like: turn-taking (how do the participants understand that particular moment), question-answer sequence (what intention or purpose can lay behind a question?), choice of word or formulation (why is this particular word or expression used, and what are the consequences?), storytelling (what does the speaker want to communicate by
this story?), and how the actions delays, hesitations, prefaces, mitigations and accounts can be used as *refusals* or *disagreements* (Rapley, 2007).

**Applied Analysis**

As previously mentioned emotions are culturally and socially generated and influenced. Based on this I have searched for ongoing emotions causing mental, bodily or behavioral reactions directed *at, about, or of* something related to the consultation (Parrot, 2001). I searched to locate these signs of emotional distress through mainly verbal, but also nonverbal language and communication linked to the incidence of not being understood. Since my interest was to learn how patients express emotional distress, I related not to be understood to whether or not a goal is perceived or believed to be achievable (Ben-Zeév, 2010, Harris 1989). In medical situations this can be illustrated by a patient trying to express for example a concern, a need, a doubt, hope or a contrasting opinion or view.

The emotional labels referred to in the excerpts were taken from basic emotion prototypes consisting of 135 emotion terms materialized from a hierarchical cluster analysis (Shaver, Schwartz, Kirson & O’Connor, 2001). These 135 prototypes of emotions are connected to 6 overlaying categories of love, joy, surprise, sadness, anger and fear (Shaver et.al, 2001). The explanation for applying these prototypes as label terms was to help me stay focused on my topic, and produce results that can be compared to other research and not the least to the PhD-project I have joined. Still there is a risk in attribute meaning of an emotion especially in a cross-cultural study where the researcher has to be very careful and aware of their own language and formulations (Wierzbicka, 1999). Because of this concern, I have searched to give a detailed description on how emotions are expressed. Further to illustrate just how complex and subtle the expressions of emotions turned out to be, I found it necessary to include longer excerpts than just a given/specific instance. The excerpts used have been selected to demonstrate the variety of *situations* where the patients do not seem understood, the various *ways* for patient responding, and the various *emotional* reactions interpreted. The different practices are recognized as approaches to attain understanding. Even thought they are presented as individual approaches, they were also appeared as alternating and intertwined.

**Results**

In this study I have been looking what kinds of interactions can be observed when the patient does not seem to be understood in intercultural medical consultations, and further what
can be interpreted as the emotional content of those interactions? I will now set out the findings that have emerged through analysis informed by discursive and conversation analytic approaches. The results will be presented in two parts: interactions and emotions when patient is not understood, and interactions and emotions when patient seems understood.

**Interactions and Emotions When Patient is not Understood**

I have grouped the various practices and emotions have grouped my findings into five areas: justifications, building alliance, showing politeness and respect, rhetorical reasoning and a direct argument. For each of these five areas I will illustrate the analysis with related excerpts.

**Justifications**. The first excerpt is taken from an early part of a consultation between a Norwegian doctor and a Norwegian patient. The patient has suffered from condyloma (infection of the genitals) for many years, and is still in distress. The patient has seen the doctor before. In the following excerpt there are three people in the room: the doctor, the patient and female. The doctor and the patient are both males and estimated to be around 50 years of age. The female, is out of the camera’s view, but from her voice I estimate her age to be slightly younger. The excerpt starts when the doctor switches from small talk to medical issues:

**Excerpt 1** (Video 129, D: doctor, P: patient and W: woman, 01:34 of total 39:02 minutes)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>24</td>
<td><em>D:</em></td>
<td>Yea, you are not the easiest patient (...) hm, a little</td>
</tr>
<tr>
<td>25</td>
<td></td>
<td>TRICKY</td>
</tr>
<tr>
<td>26</td>
<td></td>
<td>((Doctor leaning a little further towards the computer))</td>
</tr>
<tr>
<td>28</td>
<td><em>W:</em></td>
<td>He feels it’s becoming worse and worse every time he comes here, so I don’t know (light laughter)</td>
</tr>
<tr>
<td>29</td>
<td></td>
<td>how it is coming here-</td>
</tr>
<tr>
<td>31</td>
<td><em>P:</em></td>
<td>(overlapping) yea because now it’s getting worse, now it has started to grow out more of those (...)</td>
</tr>
<tr>
<td>33</td>
<td><em>D:</em></td>
<td>Yes</td>
</tr>
<tr>
<td>34</td>
<td><em>P:</em></td>
<td>More of those, but (mumbling) it’s YOU who have to find out what is causing this, so you can make it stop, you know.</td>
</tr>
<tr>
<td>37</td>
<td></td>
<td>((The doctor keeps looking at the computer, looks at documents on the computer. Does not look at the patient))</td>
</tr>
</tbody>
</table>
D: Yes (.) because it seems, I think I’ll return to the previous script- ((Patient gesticulates with his hand))

P: That would have been very nice. So if I could have found a pill or a salve or-

D: Eh (.) now you correct me, because here I have a pretty long and good script, I believe, and this is from (date), and here I’m writing that du in (year) had a condyloma surgery (.) in (year) so (years) ago almost, then you had a surgery for condyloma in the anal area. Then you were fine until (year) when you had expansion around the anal area again

The doctor starts by calling the patient ‘tricky’ (line 25). This may be a friendly or joking way to steer the conversation from small talk to a medical focus and the patient’s health situation. Right after this the woman adds how the patient does not like coming to these medical visits and how he feels it is getting worse and worse. It is not clear what relation this woman has, and since she is not seen in the filmed area her appearance does not give any clue to this. Her statement can be a prolongation of the doctors small-talk, but I interpret this more to be an invitation to the patient to explain how it feels to be “the tricky” patient. Having been labeled as ‘tricky’ and described as not happy about the consultations, we can sense an urge in the patient to justify or explain this position. The patient clarifies why he does not like the medical visits and how his problems are getting worse (line 31). When the doctor, seemingly untouched by the patients’ concerns, replies with a short ‘yes’ and keeps staring at the computer, the patient becomes more assertive and states the doctor’s responsibility (line 34). Again the patient fails at evoking a response. The doctor replies with another ‘yes’ and changes the topic to a medical note he has found in the medical record on the computer. This change of topic may also indicate that the ‘yes’ was connected to the new focus, in other words that the doctor did not pay attention to the patient’s previous statement. The patient now tries a third approach and expresses a potential gratitude if the doctor succeeds at finding a medication to soothe his pain, and suggests a pill or a salve (line 43-44). Analysis of these data suggests that the patient feels bothered as he has gone through three different attempts at reaching through to the doctor; one by explaining openly about his pain and worry, two by more assertively stating the doctor’s responsibility, and three by expressing gratitude and suggestions.
Interpretation of this suggests three kinds of emotions that may have occurred in the course of the present medical consultation. We may name these emotions: embarrassment, frustration, and hopelessness. Analysis of lines 24-32 suggests the potential of mild embarrassment. This emerges after the patient has been told that he is a ‘tricky’ patient. We see here how the patient attempts to offer justification and clarification in response to the uncomfortable feeling of being one who is “tricky”. During his second attempt, lines 34-36, it is possible that the patient experiences some frustration, in that he has experienced a rejection and has become frustrated at how to reach through to the doctor. Going at his third attempt, lines 43-44, it is possible that frustration may turn into hopelessness, since he does not seem to reach through to the doctor but also more importantly with regard to the treatment of his illness. After his third attempt the doctor interrupts the patient and asks the patient to focus on the medical history (line 45-52). While the doctor may well be concerned about the patient’s illness, the analysis of this interaction suggests that the doctor is not clearly attending to the patient’s experience of his illness. Not listening, or not clearly signaling that one is listening, may lead to uncertainty and the feeling of frustration and hopelessness, on the part of the patient. The patient may be left with uncertainty about whether the doctor is interested, and about whether the doctor is able to help at all.

We will now turn to a consultation with an ethnic minority patient and a different situation of how language can be used to make oneself feel understood. The main shift goes from making direct inquiries to a more detoured or allied (“beat around the bush”) approach to the doctor.

**Building alliance.** The following excerpt is between a Norwegian doctor and a patient with foreign background. They are both males, the ages are estimated to be around 30 for the doctor and around 40 for the patient. The patient is back for a follow up after a surgery in his throat. The following excerpt starts right after the doctor has summed up the ongoing medication plan and the patient’s next follow up. The patient changes the subject to his work situation:

**Excerpt 2** (Video 371, D: doctor, P: patient, 06:53 min of total 11:57 minutes)

182 \(P:\) When eh I’ll be back at work (light laughter)
183 \(D:\) How long have you had sick leave now?
184 \(P:\) Eh over a month maybe
185 \(D:\) How long does your sick leave last?
186 ((Doctor looks towards patient))
187 \(P:\) Eh last time eh the doctor gave me a week
In the first sentence of the excerpt the patient introduces his work situation as a topic. He starts the sentence by “when I’ll be back at work” and then laughs lightly (line 182). This little laughter may function as an invitation or at least an occasion for the doctor to ask a follow-up question. Alternatively, the laughter could signal some sort of triviality or informality, almost as an excuse or a topic ‘softener’ (Kovarsky, et al., 2009). Sick leave has been a tender and highly debated topic in Norwegian media over the last years, and might therefore be a sensitive subject to bring up. The doctor asks how long he has had a sick leave now, and the patient replies “over a month maybe” (line 184). The ‘maybe’ seems at first like a mundane or trivial word, but it does leave the patient a little less accountable for what is being said (Rapley, 2007). The meaning behind the ‘maybe’ can also be interpreted as a way for the patient to make the sick leave sound and appear shorter than what it really is. Further the word may also downplay the importance of the meaning, hoping that this will make the patient seem less desperate for an extension. The doctor follows up by asking a double question: if the patient feels he can start now and what his work is (line 190-191). This question seems to create the basis for the misunderstanding, because the patient only answers...
the second part of the question (‘cleaning’) and not the first part (line 192). Based on this ‘mistake’ the patient now seems to enter a detour in his communication. When the doctor next states that he believes the patient to be well enough to start work, the patient does an attempt at expressing a desire for a longer sick leave period, and asks “is it possible next week?” (line 195). This question can be interpreted in two different ways. Either, as may seem obvious being aware of the patients’ intention, if the patient can wait to start until next week, or, as the doctor seems to interpret, if the patient is healthy enough be working next week. The second interpretation implying that the patient would like to start working. The doctor responds by stating that this is fine and that the patient can start work soon. Through the hesitation at the end of the patient’s answer we can sense that the patient may have doubts: “Yea next week I can e-eh” (line 197). When the doctor appears to close the topic, continues to write on the document, the patient seems to realize that the doctor has not understood his intention. The patient says “it’s boring at home” and laughs lightly (line 199). A way to interpret this utterance is that the patient would like to give the impression of wanting to go back to work, build or add to a story he assumes the doctor would like to hear. Through building a story the patient may build an alliance with the doctor, and further strengthens his position before making another attempt at asking for an extended sick leave. When the patient finally asks directly if he can have another week of sick leave the doctor replies that he can get sick leave the remaining days of the week.

As the sequences indicate the patient responds to not being understood in a conforming and neutral manner. Conforming in the sense that the patient tries to adjust and tune his behavior according to what he assumes the doctor is expecting. Neutral in the sense that there are few emotions openly expressed. These are both elements typical for a collectivistic culture (Fernández et al., 2000). The patient appears fairly neutral in body language and facial expressions; it is mainly through verbal reasoning and explanations that we sense that he is not seemed understood, and by use of hesitation and laughter. The analysis can therefore suggest that the patient experiences a certain disappointment or despair as his wish was at first not understood by the doctor (lines 196-198). The patient may further have experienced the doctor to “invalidate” his wish by stating that the patient can start work now very soon (line 196). This interpretation may explain the patients “matching” when he says that he is bored at home (line 199). When the patient finally seems to find the right occasion to ask directly for a prolonged leave he seems to have achieved his goal, to get an extended sick leave.

Above we saw how an ethnic minority patient used ambiguous and indirect enquiries before he asked directly about getting an extended sick leave. The patient demonstrated good
language skills, certainly good enough to resolve the misunderstanding. Compared to the situation in excerpt 1 where the patient seemed to justify his goal or concern, the patient here in excerpt 2 seemed to get what he wanted and resolve the potential misunderstanding through becoming allied with the doctor in achieving his goal. In some cases the patient does not seem to have the language skills or capacity to justify or talk his way into achieving his goal. We will now turn to a situation that gives an example of just this.

Politeness and respect. The third excerpt is taken from a consultation between a Norwegian doctor and an ethnic minority patient, and is the shortest consultation in the data (only 6 minutes and 20 seconds, the videotaping itself lasted longer because the camera kept running). The doctor and patient are both males, the doctor appears around age 40 and the patient around age 60. The medical issue is not stated directly, but as the doctor goes through the medical history it appears that the patient is recovering from an infection in the lower abdomen, with a swollen area that is leaking fluid. Throughout the consultation the patient appears rather quiet, but alert. He talks in short sentences and employs little descriptive language but uses more definite and direct language when asking and answering questions:

Excerpt 3 (Video 198, D: doctor, P: patient, 02:58 min of total 08:35 minutes)

71 P: Infection now?
72 D: No I don’t believe so
73 (Doctor washes his hands, patient turns around
74 half way towards the doctor))
75 P: No. No infection. So (maybe?) there comes just a
76 little water (,) this just water
77 (The doctor walks back and sits down on his chair
78 and pulls towards his computer))
79 D: Yes, com- there is running a little yes yes it will
80 probably cease I believe but eh (,) we should take a
81 few blood tests
82 P: Today?
83 D: Yes

As seen in the above excerpt the patient uses few words in his utterances, and especially when asking questions, but also in his replies and search to verify that the fluid is no longer a health risk. As the consultation is rounded off, the doctor reassures the patient that his problem area will be fine and healed. Based on the exchange of words and utterances during the consultation, there are no apparent indications that the patient does not seem understood. The patient does show some impatient and alert body language (e.g. gaze flickering around the
doctor’s office, glance at the camera, a nod and smile to a third person (out of the cameras’ view), upright and observant posture, glances at doctor’s computer), the patient appears comfortable and content even though he is rather quiet. He answers politely, is willing and agreeable to the checkup and smiles and laughs a few times during the talk. As the consultation has formally ended, and the patient has stood up and has walked out of the recorded area, the conversation continues:

**Excerpt 4** (Video 198, D: doctor, P: patient, 05:20 min of total 08:35 minutes)

158  P:  So (xxxx) is filming (xxx)
159  D:  What did you say?
160  P:  Filming?
161  D:  Yes it’s just (.) they are (.) they are doing some filming about like how it is at the office here and how we are doing with the patients and so forth ((Doctor gets up walk towards the patient))
165  P:  Right, good good (laughs)
166  D:  To find out if we can get any better
167  P:  Yes yes
168  D:  I think
169  P:  (laughing) ((Doctor stretches his arm out to one side and walks out from the filmed area))
172  D:  We’ll see
173  P:  Yes, thank you very much. IT it is when it’s done on all (xxx xxxx) that it will be gone NOT come back again afterwards?
176  D:  No it’s not supposed to (.) usually not-
177  P:  Usu-usually I’m about (xxxx xxxx) I a little small
178  D:  Yes?
179  P:  When I started (hospitalized?) (name of hospital) then I (xxx xxxx) then ‘no it’s just water’ and then after (.) about ten years after then they big? When i at follow up ‘oh this just water’
183  D:  Mmm, it’s just water really but-
184  P:  Yes yes, but (xxx xxxx) (leave?) again (light laughter) yes?
186  D:  Yes
187  P:  Thank you very much
188  D:  Thank you for now at least
The patient picks up the conversation by talking about the filming. This can be either because he is concerned about the filming, but also a way to reopen the conversation with the doctor. The closing phase of the consultation has been identified as a time when patients tend to express emotions (Zimmerman et al., 2007). In this case, the patient seems agreeable and positive when responding to the doctor explaining the filming. Before approaching the medical issue he starts the sentence with ‘yes’ as stating an agreement with the doctor, before expressing his gratitude “thank you very much” (in line 173). The agreement and gratitude expressed may serve as a ‘softener’, or a preparation for what is to come. This softener may have several functions. One interpretation could be that the patient wants to gain compassion and sympathy from the doctor and further increase the chances that the doctor will be explicative and understanding. A second interpretation could be that the patient wants to assure the doctor that reentering the medical topic does not mean that the patient is not content or does not have faith in the doctor. Since this patient is Pakistani I draw a parallel to another consultation with another Pakistani patient who expresses gratitude to her doctor for the treatment she has received (same consultation as excerpt 11 is from). Gratitude can be related to politeness, a central cultural element related to the collectivistic culture (Fernández et al., 2000). A third interpretation could be that the gratitude is a way to steer the conversation back towards the consultation, and therefore make it more natural to ask a medical follow-up question. When the patient now takes the opportunity to ask his medical concern about the infection, this is done in a way as to validate what the doctor has said earlier. The patient continues and states that he normally is “small” where he now is swollen, and continues explaining how he was told, when hospitalized years back, that “it’s just water” (lines 177-182), possibly implying doubt to earlier treatment since the symptom now is back. The doctor does not seem to catch the possible skepticism and answers that “it’s just water really but” (line 183). After the doctor’s “but” the patient continues “yes yes” and keeps focusing on the swelling and how it may “leave again” (unfortunately due to quiet speaking not all parts are heard and identified) (line 184). The doctor confirms again.

Based on this analysis a possible interpretation is that the patient has experienced worry during the medical condition. Even though this was not directly observed through the verbal communication, the patient has shown curious and alert body language and brought up the medical issue at the end of the consultation. These general bodily impressions may lead to interpretation of the patient as apprehensive. Later, after the patient had brought back up the medical issue, there is a chance that the patient may have experienced embarrassment or even regret as the doctor did not catch his possible worry or concern (line 186). A feeling of
embarrassment could also have caused the “interruption” of the doctor towards the end of that same sentence. A final consequence of the doctor not catching the patient’s concern may further have led the patient to experience some sort of despair. In relating this incidence to respect for authorities, an explanation could be that the patient was caught in the dilemma of wanting more information and reassurance for his health, while also being conscious and careful of not wanting to impose on the doctor, in addition to being insecure of his own language and communication skills.

As we saw in the above example the patient did not manage to fully front or express his worry or concern. He attempted towards the end, but did not appear secure enough to express this as directly as he maybe would have liked. Common for the three cases analyzed so far is that the doctors have not seemed aware of the patients not feeling understood. The next excerpts will illustrate situations where the patient searches for an understanding and the doctor engages in this search.

**Rhetorical reasoning.** The following excerpts are between a doctor of foreign background and a Norwegian patient. The doctor is a female, age around 50, and the patient is a male around age 70. There are three excerpts from this particular consultation, since all three show interesting instances of how the patient tries to achieve understanding from the doctor. The patient is experiencing great amount of pain in his legs, pain that is affecting much of the patient’s everyday functioning, as his sleep, mood, hunger and social life. After the doctor has gone through a patient form in details and done a health check, the patient while standing getting dressed says:

**Excerpt 5 (Video 607, D: doctor, P: patient, 26:35 min of total 45:42 minutes)**

520  *P:* Yes one thing I have forgotten
521  *D:* Yes
522  *(Patient takes out something from his pocket, sits down, and places a small piece of paper on the table, looks like a label from a drug.)*
523  *P:* (xxx) that I will try now but I have not (..) anywhere to (write this on now?) (pause) THIS I got this a month or so ago to try and then like ‘oh antidepressants’ isn’t that what they call it?
528  *P:* (xxx) that I will try now but I have not (..)

The patient has brought a medication label to show the doctor. When the patient says: “’oh antidepressants’ isn’t that what they call it?” (lines 527-528) he refers to the drug as something he has little knowledge about and interest in. In formulating the name of the drug
through a mimicking voice, he signals an attitude of judgment. Further he refers to ‘they’ (line 528) as if he wants to distance himself from the ones who suffer from this mental illness. The statement could also be intended to let the doctor how he has “discovered” the prescription not to be a painkiller, as he initially wanted, but an antidepressant. One way of reading this passage is that the patient perhaps could be feeling annoyance or anger over being put in the “wrong” category and fear of not getting the help he desperately wants; help to soothe his pain. A few minutes later the patient describes the effect of the antidepressants:

Excerpt 6 (Video 607, D: doctor, P: patient, 27:45 min of total 45:42 minutes)

562  P:  But eh I have not (light laughter) felt any change-
563  D:  (Overlapping) mmm-
564  P:  (Overlapping) and not and my wife SHE would
565  D:  have I don’t know others maybe would have
566  L:  noticed if I had gotten-
567  P:  Yes exactly (.) mmm
568  L:  (The patient leans forward over the table picks up
569  the label and holds it in his hands))
570  P:  So eh I’m telling this in my own words-
571  D:  (The doctor looks through the form, patient
572  leaning back resting his head in his hand, leaning
573  towards one side of the table))
574  D:  (Overlapping) Very well because based on the test
575  that you have filled out yourself-
576  L:  Yes exactly (.) mmm
577  P:  ((Doctor pointing at the form))
578  L:  It shows that you do HAVE depression
579  P:  Yes that shoul-
580  D:  (Overlapping) and the fact that you lose weight
581  that you have depression a-and you have a
582  depression that needs treatment, but there is
583  medication that can help you (.) so-o-o we could
584  try something else that helps both your pain and
585  the depression
586  L:  ((Patient sits leaned back and looks at doctor))
587  P:  Yeah-
588  D:  Mmm
589  P:  Well yes I’m eh willing to-o-o
590  D:  (Doctor takes draws lines in the form))
591  D:  Yes (.) we will try the new medication (long pause)
592  L:  ((Doctor glances towards the computer and back
593  towards the form. Patient sits quietly leaned back
594  in chair))
In the first line of the excerpt the light laughter may defuse the annoyance or anger the patient at this point may experience (Kovarsky et al., 2009), or it could also serve as an amplifier of how little effect the drug has had on the patient. The patient continues to tell how not even his wife has seen any effect. By referring to how others have not seen an effect, he strengthens his argument and further builds credibility by showing insight of his own limitation as an objective evaluator. The doctor confirms but does not show further understanding or support. The patient now seems to play his last card and says “So eh I’m telling this in my own words-” (line 570). This sentence can be meant as a plea for the doctor to listen and believe in what the patient has just said. Further it can be a form of loud thinking of being close to give up the struggle to be understood, that there is nothing more he can do. The doctor, now building on this particular utterance, ties the patient’s own words to the diagnosis, showing how he himself through the patient form has given signs of depression. At this point the doctor seems to have the rhetorical supremacy, in showing so clearly that this is not her decision but rather based on the information the patient himself has given. By how the patient starts the next utterance “yes that shoul-“ (line 579) there is a possibility that the patient is on his way to utter some form of understanding for what the doctor has just said. The utterance comes spontaneously, possibly tied to being stunned of what the doctor has just stated, but could also be an unconscious action of being polite and agreeable. The doctor argues her opinion based on information from the patient form. At this point there seems to be a change in the patient, going from somewhat active to lesser energy. This is also supported by the patient’s body language. The patient has been sitting upright or in a leaning forward position, sometimes leaning to a side on the table supporting his head in his hand. The patient now appears to resign and gives short answers in form of hesitations. His body language is now leaned back in the chair, with a gaze still focused on the doctor. The doctor does modify the situation slightly by saying that she will also prescribe pain medication and that she is open to try out other medication if the suggested combination does not work (line 583-585). From observing this sequence the misunderstanding can be interpreted as if the patient sees the depression symptoms as a consequence from the pain he experiences, while the doctor sees the depression symptoms to be (or to have become) an independent condition on its own.

The analysis so far can possibly propose three different phases of emotion. First, it seems as if the patient starts out somewhat tense and anxious while arguing how the medication has not worked on him (lines 562-570). When the doctor claims that the patient form is showing direct verification of depression, this analysis reads the patient to here go into
a momentary feeling of surprise (line 579) before this emotion outwardly appears to turn into despair and sadness (lines 587-594). As the doctor gives no impression of compliance or understanding, the patient may emerge to enter a state of hopelessness. At the end of the consultation the doctor invites:

**Excerpt 7** (Video 607, D: doctor, P: patient, 43:24 min of total 45:42 minutes)

1015  D:  *(Overlapping)* is there anything else you would like
1016  to ask, something you are wondering about?
1017  P: *(Sighs and breathes) (pause) (takes a deep breath*
1018  and breathes) no eh no I when I left home I had a lot of questions but eh
1020  D:  Next time you write on a piece of paper
1021  P:  Yes I’ll write it down n-no I believe I have gotten answers to eh most so WHAT is my main eh
1023  question (...) eh if you can help me to get a break from the pain THAT is what has been stuck in my mind now-
1026  *(The doctor nods)*
1027  D:  Yes-
1028  P:  For many years and the last half year when they just send me out ‘you can’t get anything then
1030  you’ll become dependent’ and yea ALL that stuff-
1031  *(Doctor shakes her head)*
1032  D:  Yes you do not have to think about that-
1033  P:  So so then you become THEN you become depressed
1035  *(Doctor nods)*
1036  D:  *(Overlapping)* then then I understand-
1037  P: *(Overlapping)* and walks out from the doctor more furious then when I came-
1038  D:  *(Overlapping)* yes I-
1040  P: *(Overlapping)* and DISSAPPOINTED to put it that way-
1042  D:  *(Overlapping)* yes I understand you very well but eh we think KOMPLETELY different here
1044  *(Patient gathers the sheets of paper)*
1045  P:  Yes eh I eh *(light laughter)* understand
1046  D:  *(Overlapping)* it will be fine
1047  P:  Thank you very much
1048  D:  You are welcome good bye
1049  P:  Good bye
1050  D:  See you later
When the doctor rounds off the consultation she asks, apparently accommodating and encouraging, if the patient has other issues he would like to discuss. This friendly backing tone is seen many places throughout the consultation, even though the doctor simultaneously can be interpreted as absent-minded and “irregular”. (For instance, in the opening passage when the doctor asks the patient about his wife and the patient explains how she has “her worries” and some heart issues, the doctor conclude with “very well” (“kjempefint”). Around half way into the consultation, when the patient tells about a previous heart surgery that did not go as planned, she replies with “OK”.) In the patient’s answer, if he can get help to “get a break from the pain” (line 1021-1025), the use of a delay, hesitation and preface (Rapley, 2007) seen in the utterance shows how difficult it seems for the patient to express his main concern; to help him get a break from the pain. Once this is said, there appears to be a change in the patient’s state, and we read more boldness and assertiveness in his frustration. He continues explaining how he in previous medical encounters has struggled to be understood and to get the right medication, and makes an imitating voice on how the medication constraint has been linked to the fear of dependency (line 1028-1030). Out from the context it seems likely that the patient is imitating other doctors, and since the patient has experienced the same skepticism again in this current consultation it seems probable that his utterance is aimed at the current doctor. When the doctor replies that the patient does “not have to think about that” (line 1032), she distance herself from this critique, indirectly saying that she does not think this way. Even though this may be true, her answer probably seems shallow and not very helpful, as the outcome for the patient is the same; he is not getting the help he wishes for. The patient uses this chance to illustrate how not being understood leads to a situation where “you become depressed” (line 1033). The doctor says she understands, an utterance that seems to have low value for the patient. The patient explains further how a person may become “furious” (“forbannet”) and “disappointed” (lines 1037-1040). I find his reference to “you” in line 1033 interesting. The patient does not say that these emotions (depressed, furious and disappointed) are how he feels, but rather that this is what you – the doctor or any normal person – would feel in a similar situation. Through this rhetorical reasoning the patient justifies his reaction and disappointment (Marcinowicz et al., 2009). Further this can be seen as a final attempt to make the doctor understand. The doctor again reassures the patient that “they” think completely different, most likely referring to the doctors at the present hospital. At this point I sense a possible disbelief as the patient answers that he understands with a short laughter (line 1045).
Based on this analysis there is a possibility that the patient did feel what he expressed indirectly above; depression, anger (as in being “forbannet”) and disappointment regarding the outcome of the consultation. His reason for presenting these emotional reactions indirectly may come from not daring or wanting to be direct with the doctor, or in the hope of evoking sympathy. This can further be tied to the fear of that his negative utterances may have a negative effect on the relationship to his doctor and further a negative outcome for his medication (Marcinowicz et al., 2009).

The excerpts above show different emotional expressions through the use of different rhetorical arguments and interactions where the patient does not seem understood. The patient and the doctor obviously perceived the situation differently, but did not have an open and straightforward discussion around their contrasting view. I will now turn to a situation where the patient and the doctor do just this, confront their misunderstanding in an open dispute.

**Direct arguing.** The following excerpt is taken from a consultation that stood out from the others for several reasons; the camera was positioned in the corner of the room and none of the participants were filmed, five people were included in the consultation (doctor, nurse, mom, dad and a child), and all participants (besides the nurse) had an accent. In listening to the voices and the topic discussed the child (who is the formal patient) appeared to be quite young (around two years) and to suffer from a serious illness. (As mentioned, for the purpose of this analysis the adult carrying the main conversation with the doctor is portrayed as the patient.) In the beginning of the consultation it is just the mom, the doctor and the nurse. After a little while the child and the dad enters the room for a checkup of the child’s stomach. At the end of the checkup the child slaps the doctor:

**Excerpt 8** (Video 611, D: doctor, P: patient/dad, M: mom, C: child, 12:29 min of total 34:40 minutes)

436  
437  M:  No no no
438  P:  No no
439  C:  (crying)
440  D:  YOU YOU (name) (name) (name)
441  C:  (loud crying)
442  M:  No
443  P:  Just forget him that
444  D:  No
445  P:  Just leave it just leave it don’t even DON’T even
446  think about (xxx xxxxxx) don’t even think about it
Both the parents react immediately after the child has slapped the doctor, and try to correct the act. The child starts crying. The doctor with a raised voice tries to capture the child’s attention. It seems like when the parents of the child, and especially the dad, realizes that the doctor tries to get the child’s attention in order to correct his behavior, the dad tells the doctor to “just forget him that” (line 443). The doctor’s spontaneous “no” (line 444), indicating that she has no intentions of letting this incident pass, or wanting to claim her right, seems to make the father more abrupt and he tells the doctor to leave the topic with a gradually increased tone volume. As the doctor justifies how she wanted to explain to the child that what he did was not allowed (line 448), the father tells the doctor that this is his business, implying the doctor should stay out of his child rearing (line 449). The doctor agrees to this but then a little later asks the father to “please” tell the child how he is “not allowed to hit the people here” (line 458). In referring to the incidence this way the doctor appears to escalate the situation and as if the child has a habit of hitting and includes other “people” to be affected. The use of the word “please” may also seem a bit provocative, especially if perceived to make the request sound more agreeable for the father. The father now replies in a seemingly similar and exaggerated way and asks how the doctor can “think any parent would tell someone to hit
someone” (line 461), which may sound as an indirect implication of accusing parents like him and his wife, to teach their children to hit. This seems to be the climax of the dispute, and as the doctor clarifies how the father has misunderstood, the father starts explaining how they “tell him” and further how the boy “has been so sick” (line 464-465). When the father says “exactly we tell him” (line 464) this can be an affirmation that they do give their child normal parental corrections and guiding, or it could also refer to other incidence of hitting and how they have corrected these episodes. In either case it seems reasonable to interpret from the father’s last utterances that both the child and the parents seem very tired and exhausted from staying at the hospital, something that is also stated several times directly and indirectly throughout the consultation.

Interpretation of these data suggests that the patient (the father) may have experienced the emotions of anger, frustration, and despair. After the hit-episode there seems to be a probable state of anger from the patient, centered at the doctor for reacting the way she did and wanting to discipline the child (lines 445-457). After the doctor’s utterance about telling the child not to hit I interpret emotions in direction of frustration emerging from the patient as he perceives being seen as someone who cannot control his child, or even feeling accused of encouraging the child’s hitting (lines 460-462). Finally as the patient tells about how tired and scared the child is I read emotions of despair (lines 464-467). The father and mother do their best to keep up the spirit for their child, and it seems very possible that they think the doctor should be able to consider the large picture and ignore a single incident like this. The analysis indicates that the parents do not feel understood in regards to how tough and draining this hospitalization and situation is.

So far we have looked at situations where the patient did not seemed understood by the doctor. To demonstrate the range in doctor-patient communication let’s turn to some incidences where the doctor do seem to understand the patient issue, and discover how emotions are expressed in these situation.

Interactions and Emotions When Patient seems Understood

In the instances where the patient did seem understood, meaning where the patient did seem to achieve his or her goal, I have chosen two cases to illustrate the interactions and possible interpretation of emotional distress: accepting an invitation and bonding.

Accepting an invitation. The following excerpt is taken from a consultation with a female doctor with foreign background (soft accent) and a Norwegian patient. The doctor’s age is estimated to be around 40-50 and the patient to be in his 30’s. The patient is suffering
from heavy stages of diarrhea and experienced recently an embolism (arterial clogging). The patient has seen the doctor before. The doctor and the patient have a seemingly open and personal tone during the consultation. The consultation has come towards the end when the doctor asks:

**Excerpt 9** (Video 652, D: doctor, P: patient, 34:30 min of total 40:20 minutes)

1003  D:    *Ehm is there now anything you are wondering about related to (...) I can help with?*
1004  P:    *No-o (sights) I have many questions but then I’ll keep sitting here today (light laughter)*
1006  D:    *Yes is there anything you are holding back now*
1008  P:    *No eh I have a lot (...) wondering about (...) this thing surgery and can we can manage this with medications than that is best but in regards to side effects from the medications and*
1013  D:    *Mmm*
1014  P:    *Like the embolism could that be a side effect from any of the medication I’m taking?*

The doctor’s question appears to be a typical issue as the consultation is rounding off; if there is anything the patient would like to ask. The short pause in her question (line 1004) can signal calmness. The patient’s answer is characterized by the use of hesitations and an out-breath, possible indications that this is difficult for him. The light laughter is also typical for reducing the severity of an issue (Kovarsky et al., 2009). The patient explains how he has several questions, too many to ask. The doctor encourages him to talk by asking if there is something he is holding back (“noe du brenner inne med”) (line 1007). By phrasing herself this way the doctor indirectly invites the patient to disclosure and signals understanding. Again we get a strong sense of how difficult this must be for the patient, as he answers loosely and by a hesitation and pauses (line 1009). A way to analyze this is that the patient may feel a split between questioning and being positive in regards to the medication and the treatment. The doctor’s comment “mmm” may have seemed encouraging since the patient finally asks what appears to be a central concern; the possibility of the embolism being a side effect from the medication (line 1014-1015).
The doctor and patient discuss this issue, and the doctor assures how a causal relation between his medication and embolism is not known. They further discuss the patient chances of becoming well, and the doctor explains how “they are not at the end of the scale” meaning how there are still alternative treatments and medications to try. The patient seeks reassurance of this:

**Excerpt 10** (Video 652, D: doctor, P: patient, 39:50 min of total 40:20 minutes)

<table>
<thead>
<tr>
<th>Line</th>
<th>Transcript</th>
</tr>
</thead>
<tbody>
<tr>
<td>1140</td>
<td>P: There are still ways until (the end?) still</td>
</tr>
<tr>
<td>1141</td>
<td>D: Yes there are</td>
</tr>
<tr>
<td>1142</td>
<td>P: Mmm (.) yes?</td>
</tr>
<tr>
<td>1143</td>
<td>D: So that was THAT was what you were holding back</td>
</tr>
<tr>
<td>1144</td>
<td>D: now (..) the most</td>
</tr>
<tr>
<td>1145</td>
<td>P: Yes eh (..) more questions will probably come after</td>
</tr>
<tr>
<td>1146</td>
<td>a while but you don’t have the whole day</td>
</tr>
</tbody>
</table>

The patient’s question, seemingly seeking proofs of what the doctor just has explained and if there is hope for him to get better (line 1140), shows his insecurity and pessimistic outlook. The doctor confirms that there are still ways for them to try, and double checks by asking if this concern was what the patient was holding back and adds “the most” (line 1144). This little addition “the most” can be an indication for the doctor to show her understanding for the fact that the patient may have more concerns, but could also be a mild way for them to round off the session indicating that the other issues, less critical, will have to wait till next time. The patient seems to catch this since he replies how the doctor does “not have the whole day” (line 1146). The doctor tells the patient towards the end that they will schedule a new appointment, and that he can call her directly anytime.

Based on this analysis the doctor seemed very attentive of the patient’s concerns, and managed to build the trust and understanding for the patient to express his concerns gradually more directly and open. This way she invites the patient to disclose his emotional concerns. The emotions interpreted could be concentrated around two emotions; insecurity and hopelessness. When the patient was given the opportunity to talk about what he was holding back, I sensed through the hesitations prefices (lines 1005-1012) signs of a possible insecurity. When the patient finally asked what appeared to be one of his key issues, the possibility of a causal effect between his medication and the embolism, the hesitations and prefices could also be an interpretation of the insecurity stretching in the direction of embarrassment or a mild form of shame. A possible embarrassment could be connected to the patient’s doubt regarding the medication, as the doctor in the outermost consequence could...
perceive his question as a critique or skepticism directed at her. Towards the end of the consultation, after the doctor asked if this was what he was holding back the most (line 1143-1144), there may be still signs of hopelessness in his answer as he confirms with a hesitation (line 1145) and states that there will probability be more questions coming.

The patient did state a concern around anxiety when he told the doctor how he had a “little history with anxiety” (in the middle of the consultation). I interpreted the patient’s goal to be concerned around medical assurance; first of all declaring his fear around a possible causal effect between the medicine and his embolism, and second of all to get assurance that there are chances for him to get better. Because of the doctor’s open, attentive and considerate behavior, constant follow-up questions and active listening the patient’s negative emotions seemed to be concentrated around the medical issue, and not spent on efforts in trying to make the doctor understand.

Here we witnessed a doctor being open, calm, awaiting and giving room to the patient, so that he could ask the questions needed to attain understanding. The next, and final excerpt, will demonstrate another doctor-patient interaction where understanding and bondage is achieved quite early in the consultation. Here the doctor not only makes herself available, but she seems to take an active role in securing patient understanding.

**Bonding.** This last excerpt is from a consultation with a Norwegian female doctor, an ethnic minority female patient, and the patient’s mother. The doctor’s age is estimated to be around 30 years and the patient to be around 20 (probably younger). The excerpt is taken from the very start of the consultation, as they have just greeted and sat down:

**Excerpt 11** (Video 100, D: doctor, P: patient, 00:25 min of total 15:43 minutes)

14   ((Doctor sits down and pulls out the chair out from the desk, so that she is positioned close and towards the patient and her mother))
15   
16   D: Yes, there has been a lot of hospitals for you lately
17   ((Patient takes off her shoulder bag, light laughter))
18   
19   P: Yes lots of hassle
20   D: Tired
21   P: Yes
22   ((Doctor nods))
23   D: You have recently stayed with us too
24   ((Patient leans back in the chair, rests her elbows on the end of the desk, smiles.))
25   
26   

Based on how the doctor positions herself towards the patient and use of eye contact creates right away a sense of personal and warm atmosphere. The doctor opens the conversation by stating how the patient has spent much time staying in hospitals during the recent time. This utterance shows both understanding and acknowledgement of the patient’s situation. The patient comments how it has been a “hassle” (line 20). By responding back the single word “tired” (line 21) the doctor demonstrates active listening and thoughtfulness, and again invites the patient to continue expressing herself. The patient confirms again. After the doctor has states that the patient also has been staying at the present hospital, the patient now declares, at the same time as she smiles, a direct dislike of staying in hospitals. The doctor “legitimizes” the patient’s declaration by repeating the statement with light laughter, before she again states her understanding (line 29). Kovarsky et al. (2009) connects this kind of laughter, as a form of friendly teasing, as part of a process to foster rapport and social closeness (Kovarsky et al., 2009). The patient now states that it has been ok “really” (“egentlig”) (line 30). This is another example (compared to the word “maybe” in excerpt 2) of how a word may seem ordinary and dull, simultaneously as it comprises a meaning. In this context the “really” may be a way to soften the previous utterances about her dislike of hospitals. The doctor gives the patient a chance to reflect on this and asks “you think so” (line 31). The patient confirms before she switches over to difficulties regarding medication, and expresses how something has been difficult. The doctor makes a guess if this has been related to being responsible for
medication herself (line 40), and the patient confirms. Again the doctor searches to find the exact issue of distress, and states that it’s good when someone makes the dosages. The patient confirms again.

We can see how the doctor guides the patient in disclosing by open up ways for her to express her emotions, and how the patient seems open and trusting towards the doctor – as if there has been a bonding. Frankel (1995) presents some skills for empathic communication such as allowing the patient to tell her story, showing appropriate and genuine interest and attending to concerns over shame and humiliation (Frankel, 1995). Based on the above analysis the doctor appears to cover all these considerations in her communication with the patient. The patient appears fairly neutral during the passages in the excerpt above but seems to signal mild signs of optimism, still there is no doubt that by being a cancer patient (appears later in the consultation) she is highly likely to experiences this as a stressful stage in her life. Through the doctor’s questions the patient expresses tiredness and displeasure about staying in hospitals and being responsible for her medication. Still, some kind of contentment and optimism can be interpreted to her statement of how things have “been ok really” (line 39).

As we saw in this last excerpt, it was not so much how the patient practiced her interaction, but more so how doctor that guides and facilitate disclosure and understanding.

**Summarized Results**

The excerpts above present a variety of practices and approaches observed in the interactions analyzed; justifications, building alliance, politeness and respect, rhetorical reasoning and direct arguing. To illustrate negative or contrasting cases two situations where the patient did seem understood was added to the analysis. These cases illustrated how a patient accepted an invitation (to disclosure) and how the patient seemed to bond to the doctor. The excerpts used are selected from seven out of twelve consultations and were chosen to illustrate the variations of situations, ways of responding and emotions interpreted where there seemed to be an issue of understanding. A work summary of situational interactions and emotional interpretation from all interactions are presented in model 1 (see Appendix C).

**Discussion**

This study examined how to understand patients interactions when they do not seem understood in intercultural medical consultations, and further which emotions could be interpreted in these situations. My findings are overall similar to previous research in that
patients in intercultural consultations mainly express concerns indirectly and in combination of verbal and nonverbal signals. Further, my analysis did identify a variety of approaches of interaction used when patients did not seem understood. The emotions of sadness, fear and anger were most often interpreted.

Previous research illustrates in general a challenging situation for ethnic minority patients in medical consultations. Among others, there appear to be more frequent language obstacles (Ashton et al., 2003), diminished interaction and disclosure of information (Rawls, 2000), and less affectionate communication from the doctors and fewer expressions of concerns from the patients (Schouten & Meeuwesen, 2006). With the premise that doctors often believe their patients’ ideas to be similar of their own (Street & Haidet, 2010) it is crucial to learn more about how patients’ emotions and concerns in medical encounters. Although these and other studies present broad knowledge and insight of ethnic minority patients’ situation, they may not apply to the Norwegian context in the same way as for the countries where the studies originally were conducted.

My analysis revealed differences in communication and interaction between ethnic minority patients and ethnic Norwegian patients, but did not disclose as distinct variations as I initially had expected. One explanation could be that in comparison to some studies for example carried out in the United States, (where participants self-identified as Blacks and Whites) (Rawls, 2000), the Norwegian society does not appear as prominent regarding ethnic or cultural categories. Secondly, as globalization develops, the intercultural situation may merge in a direction of more compounded and intertwined societies. Thirdly, since my data set consisted of doctors with foreign background, this added another cultural dimension to my analysis; and therefore may have functioned to nuance the potential outermost findings.

The situation of not being understood appeared to vary in character and content, as a patient experienced not to be understood versus misunderstood. Not understood, I interpreted to be a scenario where the doctor shows no understanding, whereas a misunderstanding can be seen in a situation where the doctor expresses a different understanding than the patient. Based on the analysis it appeared that resolving an already existing misunderstanding seemed to be most frustrating for the patient, as this deals with changing an already established assumption or opinion in the doctor. For a little under half of the consultations the doctor appeared to not have any awareness of the patient experiencing emotional distress (see table 1 in Appendix C).

The content of the situations, the type of understanding lacking, seemed to vary from small trivial or practical issues to serious health issues. Since I related the situations of not
being understood to whether or not a goal was achieved or perceived achievable, the way these goals were met by the doctor seemed to influence the release of emotions from the patient. I recognized how negative emotional responses were more likely to appear when feedback at a task oriented level seemed interpreted at the personal level (related to self) (DeNisi & Kluger, 2000). The way some of the doctors in my study responded to or conveyed feedback did indeed seem to influence patients’ self perception, which further influenced the patients’ emotional experiences.

My analysis exposed five patterns or approaches for interaction when the patient did not appear to be understood, and illustrated two situations where the patient did seem to be understood. I will here present main findings around these interactions and suggest possible interpretations.

**Main Findings and Interpretations**

The main findings from the consultations consisted of indirect expressions, to be seen as “a good patient”, laughter, language difficulty, and emotional distress. I have also included some thoughts around situations observed where the patient seemed understood.

Similarly to how patients with anxiety expressed worries (Bensing et al., 2008) for most of the consultations in this study no single worries or concerns were voiced directly by the patients. Rather, worries or concerns were conveyed by indirect expressions. As expected verbal expressions seemed to be fairly rich, subtle and complex among Norwegian patients, whereas minority patients appeared to be quieter and ask less questions. Still both groups of patients appeared to apply distinct practices of strategies in their search for understanding, and through my analysis I recognized a variety of interactional practices such as justifications, building alliance, politeness and respect, rhetorical reasoning and direct arguing. Only one in twelve interactions presented a situation where the patient gave a negative and direct expression to the doctor. Interestingly enough this consultation consisted of an ethnic minority patient and a doctor with foreign background. Besides individual differences, an explanation here could be that the patient felt less formal with this particular doctor, since they both shared the situation of having a foreign background. Further the doctor in this case showed a rather forward behavior in that she used a raise voice and nearly a commanding tone towards the patient and the patient’s child, which made her appear emotionally engaged. This may have been interpreted as unusual and since doctors have been found to show less affection while communicating with ethnic minority patients (Schouten & Meeuwesen, 2006). Also, the
fact that the patient had his wife and his child in the same room may have strengthened his position towards the doctor.

The hesitation to express emotions and concerns can be tied to the fear of putting a negative effect on further medical care or the lack of faith in that their opinion will make a difference for the better (Marcinowicz et al., 2009).

Many of the patients in my study gave the impression of regulating and accommodating their own communication and behavior according to be viewed as “a good patient”. In almost all of the consultations the patients seem to fine-tune their language, attitude and meaning according to what they may have perceived the doctor to prefer. This can be related to the patient considering the doctor’s high position and prestige of profession, feeling dependent on the doctor’s goodwill, and concern around inducing a negative effect on further medical care (Marcinowicz et al. 2009). How this “fine-tuning” was done seemed to vary among the ethnic Norwegian patients and ethnic minority patients. Ethnic Norwegian patients would every so often drop small stories or details that would put them in a favorable light (as about telling stories of how they quit smoking, present themselves as a “strong” patient, and moderate their complaints). This tendency seemed to correspond with actual preferences seen in doctors, as for example their preferences for patients who are involved in their own care (Schouten & Meeuwesen, 2006). Ethnic minority patients seemed to rely more on smiles, gestures, and the expression of gratitude, typical characteristics for collectivistic and power distance cultures where politeness and discrete behavior is more encouraged (Fernández et al, 2000).

Laughter occurred in all in all except one consultation. The use of laughter in medical settings has been recognized to downplay or reduce the severity of a patient’s condition, often with no following response of laughter from the doctor – as this can be interpreted to not take the problem seriously (Kovarsky et al., 2009). This particular pattern was noted in my data. In addition, laughter also occurred in friendly talk by both the doctor and the patient, in a form that promoted closeness and rapport. This form of distribution of laughter can be tied to a communicative symmetry between the participants (Kovarsky et al., 2009). Also this type of laughter promoting social closeness was seen in most of the consultation. Thus, the sharing of social laughter did not seem as affected by cultural differences as other elements. A possible explanation could be that the medical setting in Norway may be less formal compared to other power distance countries or cultures. Further, the ethnic minority patients observed may have gotten accustomed to this type of less formal institutionalized interaction.

Overall language seemed to function well in the consultations observed. In the cases where language did seem to be a barrier, there was naturally less talk. This was experienced in
mainly two of the intercultural consultations. In compliance with previous research, the patients experiencing language barriers would use neutral words and expressions like “OK”, “fine”, “that’s not a problem” (Steine et al., 2000). In these incidences both the doctors and the patients appeared to miss out on important nuances. One explanation why the remaining minority patients (out of totally six minority patients in my data) did well in regards to language and communication could of course be individual differences such as length of stay in Norway or extent of similarity to health system in the country of origin (Småland Goth et al., 2010). In the situations where language did seem like an obstacle, I expected body language to be more prominent. As mentioned I was not able to see the face of all patients because of the positioning of the camera, but I could see the bodily posture at all times. In combination with language difficulty only one patient had significant body language (such as change of postures, alert and gaze flickering around the doctor’s office, glance at the camera and doctor’s computer), but also here not as prominent as I had expected.

As discussed above; the use of indirect expressions, the desire to be seen as “a good patient”, the use of laughter, and the prevalence of language difficulties all contribute to create a “soft” and ambiguous atmosphere where the concerns and worries may easily seem “concealed” and diminished.

The most common emotions seen throughout all the consultations were sadness and fear, with a few occurrences of anger. Negative emotions were interpreted in all consultations, but in the situation where understanding was resolved, the consultations did seem to end with certain anticipation. As seen from the main findings in this study, emotions were expressed in subtle and complex ways. Consequentially, emotions often appeared quite intertwined and therefore became challenging to identify and locate independently. Still, based on my analysis I made an attempt to interpret and propose certain emotions connected to each consultation (see table 1 in Appendix C).

The above findings are applicable to the situations where the patient did not seem understood. What can we say about the situations where there seemed to be an understanding?

Overall, patient centeredness, a close dialogue, follow-up questions and awareness of patients needs came out as a central feature in situations where the patient seemed to be understood. Being aware of the correlation between uncertainty and anxiety (Gudykunst, 2001), results from my study did illustrate how crucial information and reassurances are for many patients. This was apparent as patients in communication with open and attentive doctors tended to ask extra and repetitive and reassuring questions. By not judging, but nevertheless listen and express concerns and empathy doctor’s understanding seemed to
eliciting patients’ concerns (Bensing et al., 2008). Humor, friendliness and positive reassurance are elements observed to cultivate a trusting atmosphere for the patient (Lo, 2010). At the same time as being open, mild, humorous and attentive, the doctors who attained understanding from the patients in my data did remain specialized and task oriented. Noteworthy, the gain from doctors’ professionalism can be related to findings of Bensing et al. (2008) where some patients linked lack of friendliness as a sign of the doctors taking their problems seriously (Bensing et al., 2008).

My main findings have summed up common features emerged from my results and analysis. I will now discuss how I can account for the quality in the findings presented.

Validity, Reliability and Generalization

Qualitative research, which has been increasingly accepted in health research, can be evaluated according to the criteria of validity and reliability (Mason, 2002; Mays & Pope, 2000, Silverman, 2006).

Validity, another word for “truth”, is a judgment about whether we are measuring what we are supposed to measure in our research (Mason, 2002; Silverman, 2006). Silverman suggests two central ways to claim validity in qualitative research. One way, triangulation, is a form of comparisons between different methods (such as interviews and observation) or between different data (e.g. qualitative and quantitative) (Silverman, 2006). Since my study is a part of a larger PhD-project that has applied a quantitative method, triangulation will be performed in the final comparison. However for my independent study this criterion is not met. Neither was I, on the basis of my topic and context, able to account for the second way, respondent validation; a way where the participants themselves can study and verify my findings. Other validity criteria are a clear composition of methods and analysis (transparency), a clear and understandable epistemological standing, attention to negative cases, and reflexivity (Mason, 2002; Mays & Pope, 2000, Silverman, 2006). Through my work I have searched to give detailed descriptions and accounts for my epistemological and methodological positioning, and to be transparent about my methodological and analytical procedures and choices. My research question has been redefined and tuned throughout the project in order to comprise the participants’ experiences and to account for a valid analysis. Further, I have attempted to support my findings by presenting negative or contrasting cases. This has been done by describing the situations where the patients did seem to be understood, as opposed to solely focusing on the situations covered in my research question; the situation where patients did not seem to be understood. Reflexivity, a criterion for making valid
qualitative research, means to be sensitive to how the data has been collected, shaped and analyzed (Mays & Pope, 2000). During my research I have tried to reflect around my role as a researcher, and how my position as an ethnic Norwegian female, inexperienced with minority health, may have influenced my findings. I have searched to be aware of my own reactions, judgments, and assumptions in order to “ensure that it is the respondent’s voice that is represented, listened to and understood rather than the researcher’s” (Bhopal, 2010, p. 193).

Reliability can be described as a way to judge the accuracy and precision of the research tools or instruments and is related to the consistency and trustworthiness of the research findings (Mason, 2002). A reliable research should be possible to replicate by other researchers. I will claim that this criterion has been highly considered through a detailed, accurate and procedural description of my research procedure.

Generalization can be recognized in two ways: empirical and theoretical generalization (Mason, 2002). Empirical generalization, the generalization to a wider population, is difficult from the present study since I can’t account for representativeness based on my data. Rather, theoretical generalization may be more appropriate for my study. Based on my social constructionism standpoint, I assume the experiences observed to be socially influenced and formed, and therefore may be relevant for others in a similar situation or context (Willig, 2007).

**Limitations and Alternative Interpretations**

This study has some limitations. One limitation may be how my guideline for nonverbal language was not as detailed and specific as for the verbal language observed. This may have produced data not as reliable and consistent as the rest of my transcripts. Based on this realization I chose to diminish this aspect of my analysis and put more attention to verbal language – which again is the main focus in conversation and discourse and analysis. Still, I believe that there could be more and valuable findings retrieved from a stronger focus on nonverbal language. Also, a limitation could be how I defined the situation for interpreting emotional distress, tied to the situation of not being understood. There might have been other just as central approaches to emotional concerns and distress such as for example fear or worry of illness. Another limitation might be how I defined the emotions, meaning how I interpreted emotions based on the prototype approach. Maybe by not relating to a set of given terms would have made me discover a greater variety of emotions. The intention was as previously mentioned to account for comparative results. Still, the consequence may be that I missed out on finer nuances of emotional incidences.
An alternative interpretation of my findings may therefore be connected to methodology. Had I chosen not to focus on the predefined emotional terms, there is a chance my analysis could have presented less distinct emotions. Even though I searched to be cautious in interpreting the emotions observed, there is a chance that this position may have read stronger effects than what was actually experienced. Another noticeable alternative explanation is the filming and the presence of the camera in the examination room. One can speculate whether this could have had an inhibiting effect on the patients’ communication, and a motivating effect on the doctors’ patient centeredness.

Implications

There are clear indications that Norway as a multicultural society faces challenges in intercultural health communication. Ethnic minority patients have been found reluctant in seeking help and assistance from Norwegian general practitioners, and statistics show alarming health differences and overrepresentations of given illnesses in this group. As my study indicates there are a range of diffusing and indirect communicative practices or strategies used when the patients are not understood in medical consultations. These practices were shown to consist of communicative element that made mutual understanding more difficult to achieve. The study on minority health deals with marginalized individuals. As cultural research should “allow the people to speak for themselves through ethnographic studies” (Kamenou, 2007), I believe further research must focus on giving these individuals a direct voice. A combination of interviews (e.g. evaluative questions) and participant observation could for example give a broader and fuller understanding and accountability for the communicative practices and challenges. Further, focus on the separate elements taking place in doctor-patient communication can navigate access to underlying structures of intercultural communication. Research could also promote a narrower focus on for example emotional distress during the opening interview, the closing phase, or during the checkup, or to focus broader on specific emotions such as for example sorrow, shame and worry.

Conclusion

My aim for this study has been to draw particular attention to interactions observed when patients do not seem to be understood in intercultural medical consultations, and to further interpret and identify the emotional content of these situations. For my analysis, I obtained fieldnotes and produced transcripts from twelve doctor-patient multicultural consultations, and analyzed the consultations by applying conversation and discourse analytic
frameworks. My analysis identified five practices used in the patients’ strive to achieve understanding; justifications, building alliance, politeness and respect, rhetorical reasoning and direct arguing. The main findings from this study confirm earlier research which patients tend to use indirect expressions. In addition, my study did illustrate how patients would adapt their behaviour in order to be viewed as “a good patient”, and further used laughter to downplay concerns and worries. Naturally, in the situations where language seemed to be a hinderance for the patients there would be less verbal communication. Emotions recognized in the situations of not being understood were mainly in the categories of sadness, fear, and anger. This research has attained to account for both validity and reliability through mainly transparency and reflexivity. Further research on this demanding topic is highly needed. I believe a greater understanding and awareness of emotions in the medical context gives great potential for both patients’ well-being and the doctors’ ability to provide better and personalized care.
References


APPENDIX A

Transcript guidelines developed based on Poland’s instruction for transcribers
(Rapley, 2007)*

Pauses Use series of dots (…) Each dot 1/4th of a second.
For pauses from 1 to 3 seconds: (pause)
For pauses from 4+ seconds: (long pause)
Pauses within and between statements.

Laughing/coughing Indicate in parentheses: (coughs), (sneeze),
(sighing), (crying)

Interruptions When someone’s speech is broken off
midsentence by a hyphen “-“ where the
interruption occurs: “What did you-“

Overlapping speech Use a hyphen to indicate where one stop and
(overlapping) where the other takes over:
R: He said that she was imp-
I: (overlapping) Who, Bob?
R: No Larry.

Garbled speech When it’s something you don’t understand, put in
parentheses with your guess inside or x’s for no
guess: (doubled? glossed? ) or (xxxxx xxxxx)

Emphasis In capital letters: He did WHAT?

Held sounds Repeat the sounds that are held by hyphens: No-o-
o-o, not exactly.

Paraphrasing other Use quotation marks and ‘(mimicking voice)’

Intonation At the end of a sentence with an ‘?’

Notes to reader Sentence marked {note to reader}

Nonverbal features ((change of posture/movement/actions, objects
used, touch, gesture ))

Facial expressions ((smile)) ((eye contact)) ((gaze)) ((grim))

(*Some additional elements included: “Notes to reader”, “Nonverbal features” and “Facial
expressions”.)
APPENDIX B

Norwegian transcripts of excerpts used as part of my analysis and presented in Results

Excerpt 1 (Video 129, L: lege, P: pasient og D: dame, 01:34 av totalt 39:02 minutter)

| 24 | L: | Jah, du er jo ikke den letteste pasienten (.) hm, litt |
| 25 |   | TRICKY |
| 26 | D: | ((Legen lener seg lenger inn mot datamaskinen)) |
| 27 |   | Han synes at det bare blir verre og verre hver gang han kommer hit, så jeg vet ikke (lett latter) om det er noe særlig å komme hit- |
| 28 | P: | (overlapper) Ja for nå har det blitt verre, nå har det begynt å vekse ut mer sånne (.) |
| 29 | L: | Ja |
| 30 | P: | Nye sånne, men atte (mumling) det er DU må finne ut hva dette kommer fra, så du får stoppe det, veit du. |
| 31 |   | ((Legen holder blikket mot dataen, blar i dokumenter på dataen. Ser ikke på pasienten.)) |
| 32 | L: | Ja (.) for det er, jeg trur jeg skal gå tilbake til det forrige notatet mitt- |
| 33 | P: | ((Pasienten gestikulerer med hånda)) |
| 34 |   | Det hadde vært veldig fint. Så hvis jeg kunne ha finni ei pille eller ei salve eller- |
| 35 | L: | Eh (.) nå korrigerer du meg, for her har jeg et litt langt godt notat, tror jeg, og det er det som kom fra (dato) og da skriver jeg det at du i (år) ble operert for kondylomer (.) (år) altså for (.) (år) år siden nesten, så ble du operert for kondylomer i analområdet. Og siden var du bra fram til (år) (.) hvor du fikk utvekster rundt analåpningen igjen |

Excerpt 2 (Video 371, L: lege, P: pasient, 06:53 av totalt 11:57 minutter)

| 182 | P: | Når eh jeg kommer tilbake på jobb (lett latter) |
| 183 | L: | Hvor lenge har du vært sykemelding nå? |
| 184 | P: | Eh det er over en måned kanskje |
| 185 | L: | Hvor lenge varer sykemeldingen din? |
| 186 |   | ((Legen ser opp og mot pasienten)) |
| 187 | P: | Eh siste gang eh den legen gir meg en uke |
| 188 | L: | Ja |
| 189 | P: | Så også gir meg til og med i dag mmm |
| 190 | L: | Føler du at du kan begynne å jobbe nå hva jobber du med? |
| 191 | P: | Renhold |
L: Renhold ja (.) hvis du føler deg fin så er det ikke noe i veien for at du kan begynne å jobbe nå
P: Mmmmm Er det mulig neste neste uke?
L: Ja det er helt klart jeg tror du kan begynne å jobbe nå snart jeg
P: Ja nesteuke jeg kan e-e-eh
L: (svakt tale) Skal vi sjå
P: Det er kjedelig hjemme (lettt latter)
L: Jah (.) det skjønner jeg (pause)
P: (Leverer dokumentet til pasienten)
L: Sånn hvis leverer du denne ute i luken så får du da kontrolltime da om-
P: En uke
L: En ukes tid ja
P: Eh er du kan du gi meg en ukes sykemelding til eller?
L: Ja jeg kan iverfall gi deg jeg kan gi deg sykemelding ut denne uken her, det kan jeg gjøre, sånn at du begynner å jobbe på mandag

Excerpt 3 (Video 198, L: lege, P: pasient, 02:58 av totalt 08:35 minutter)

P: Infeksjon nå?
L: Nei (tror) ikke det
((Legen vasker hendene, pasienten snur seg halvveis mot legen))
P: Nei. Ikke infeksjon. Så (ksanskje?) kommer bare bitte litt vann (.) dette bare vann
((Legen går tilbake og setter seg på stolen sin trekker seg inn mot dataen))
L: Ja, kom-det det renner litt uta’n ja jah ja det gir seg nok det altså jeg tror det men eh (.) vi må bør ta et par blodprøver av deg
P: I dag?
L: Ja

Excerpt 4 (Video 198, L: lege, P: pasient, 05:20 av totalt 08:35 minutter)

P: Så (xxxx) skal filme (xxx)
L: Hva hva sa du?
P: Filme?
L: Ja det er bare (.) de skal (.) de gjør noe film om liksom hvordan liksom det er på kontoret her og hvordan vi har det med pasientene også videre
((Legen reiser seg går mot pasienten))
P: Akkurat, flott flott (ler)
L: Må finne ut om vi kan bli litt flinkere
P: Ja ja
L: Tror jeg
P:
170  (latter)
171  ((Legen løfter armene ut til siden og gær ut av
172  synsfeltet))
173  L:  Vi får se
174  P:  Ja, tusen takk. DET det er når det blir ferdig på alle
175  sammen (xxx xxx) det blir borte IKKE komme
176  tilbake etterpå?
177  L:  Nei skal ikke det (.) vanligvis ikke-
178  P:  Van-vanligvis jeg circa (xxxx xxxx) jeg litt små
179  L:  Ja?
180  P:  Da jeg starte på (legge inn?) (navn sykehus?) da
181  jeg (xxx xxx)så ‘neida det bare vann’ og etterpå (.)
182  ca ti år etterpå da de store? da jeg kontroll ‘ah
183  dette bare vann’
184  L:  Mmm, det er jo bare vanlig egentlig men-
185  P:  Jo jo, da (xxx xxx) (legge?) igjen (lett latter) Ja?-
186  L:  Ja
187  P:  Tusen takk
188  L:  Takk for i dag i alle fall

Excerpt 5 (Video 607, L: lege, P: pasient, 26:35 av totalt 45:42 minutter)

520  P:  Jo det var en ting som jeg har gjømt
521  L:  Jah
522  ((Pasienten henter noe fra lomma si, setter seg, og
523  legger en lappe på bordet til legen, ser ut som en
524  etikett.))
525  P:  (xxxx) som jeg skal prøve nå men jeg har ikke (..)
526  et sted å (skrive den på nå?) (pause) DEN jeg fikk
527  den for en måneds siden for å prøve også så
528  liksom så ‘åh depressiva’ er det ikke det dem
529  kallere ah?

Excerpt 6 (Video 607, L: lege, P: pasient, 27:45 av totalt 45:42 minutter)

562  P:  Men eh jeg har ikke (lett latter) kjent noe
563  forandring-
564  L:  (Overlapper) mmm-
565  P:  (Overlapper) og ikke og det kona HU ville kanskje
566  jeg veit ikke andre kanskje ville ha latt merke til
567  hvis jeg hadde fått-
568  L:  Ja nettopp (..) mmm
569  ((Pasienten lener seg fram over bordet tar opp
570  den lille lappen og holder den i hendene))
571  P:  Så eh jo jeg forteller jo det i egne ord-
572  ((Legen blar opp i skjemaet, legen lener seg tilbake
573  støtter hodet i hånda på siden av bord det slik at
574  han sitter litt skrått))
575  L:  (Overlapper) Veldig bra fordi ut ifra den testen
576  som du har fylt selv-
Ja
((Legen peker på skjemaet))
Så viser det seg at du HAR en depresjon
Ja det sku-
(Overlapper) og det at du taper vekten at du har
en depresjon o-og du har en
behandlingstrengende depresjon, men det finns
mange medisiner som kan hjelpe deg (.) så-å-å så
vi kan prøve kanskje noe annet som virker både på
smerter og på depresjonen
((Pasienten sitter litt tilbakelent ser på legen))
((Legen streker i skjemaet))
Ja (.) vi skal prøve det det nye medikamentet (lang
pause)
((Legen veksler et raskt blikk mot dataen og
tilbake til skjemaet. Pasienten sitter stille
tilbakelent.))

Excerpt 7 (Video 607, L: lege, P: pasient, 43:24 av totalt 45:42 minutter)

(Overlapper) er det noe annet som du vil spørre,
er det noe som du luer på?
(Sukker og puster dypt) (pause) (trekker pusten og
puster ut) nei eh nei jeg når jeg gikk hjemmefra så
hadde jeg masse spørsmål men eh
Neste gang så skriver du på en lapp
Ja jeg skal skrive opp det n-nej jeg trur jeg har fått
svar på eh det meste så DET som er hoved eh
spørsmålet mitt det er jo (...) eh kan du hjelpe meg
med å få litt fri fra smerten den DET som har sitti
i huet på meg nå-
((Legen nikker))
Ja-
I mange år og siste halve året når dem bare sender
meg ut ‘du kan’ke få noe da blir du avhengig’ og ja
HELE den duren der-
((Legen rister på hodet))
Ja du behøver ikke tenke på det-
Så så da blir du DA blir du deppa-
((Legen nikker))
(Overlapper) da da da forstår jeg-
(Overlapper) og går ut fra legen mer forbanna enn
jeg gikk inn-
(Overlapper) ja jeg-
(Overlapper) og SKUFFA for å si det sånn da-
(Overlapper) ja jeg forstår deg veldig godt men eh
vi tenker HELT annerledes her
((Pasienten samler papirene))
Ja eh eh det eh (lett latter) skjønner jeg-
(Overlapper) det går bra
Tusen takk skal du ha
Vær så god ha det bra
Ha det
Vi ses

Excerpt 8 (Video 611, L: lege, P: pasient/pappa, M: mamma, B: barn, 12:29 of total 34:40 minutes) (Samtale både på norsk og engelsk.)

(Et klask/rasp høres)
Nei nei nei
Nei nei
(gråter)
DU DU (navn) (navn)(navn)
(gråter høyt)
Nei
Bare glem han det
Nei
Just leave it just leave it don’t even DON’T even think about (xxx xxxxxx)don’t even think about it
(skriker)
No I was just goint to say that that’s NOT allowed-
(Overlapper) That’s that’s MY business
Ok
Don’t don’t even think about it
Of course you are right-
Don’t even think about it
But then please-
Don’t even think about it
That’s ok that’s ok-
(Overlapper) Forget it ok-
(Overlapper) That’s ok but then PLEASE tell him
that that’s not allowed to HIT the people here-
(Overlapper) Do you think do you eh just being (in mind?) you THINK any parent would tell someone to HIT someone? Are you out of your MIND?-
No no don’t misunderstand me I’m not that-
Exactly we tell him but the only thing is that he has been SO SICK-
I know-
And he’s SO scared of you guys-
I know-

Excerpt 9 (Video 652, L: lege, P: pasient, 34:30 av totalt 40:20 minutter)

Ehm er det noe nå du lurere på nå i forhold til
(..)jeg kan hjelpe med?
Ne-ei (puster ut) jeg har jo masse spørsmål men da blir jeg sittende her i dag (lett latter)
Ja er det noe du brenner inne med nå da-a-a Nei eh jeg har jo masse(,) lurter litt på (.) dette med operasjon og klarer vi det med medisiner så er vel det bedre men med tanke på bivirkninger av medisiner og
Mmm Sånn som blodproppen kan det være en bivirkning av noen av disse medisinene jeg tar eller?
Det finnes krefter til (slutt?) fortsatt Jah det gjør det Mmm (.) ja? Da var det det var DET du det var det som brant inne nå (..) mest Ja eh (...) det dukker nok opp litt spørsmål etter hvert men du ha’kke hele dagen
Ja, det har blitt mye sykehus på dere i det siste ((Pasienten tar av skulderveska, ler litt)) Jaha masse slit Du har nettopp ligget inne hos oss også nå ((Pasienten lener seg litt tilbake i stolen, hviler aluoen på enden av legens skrivebord, smiler)) Ja (...) Jeg liker ikke sykehuset så lenger mye men (Ler) Du liker ikke sykehus så mye nei det skjønner jeg godt Men jeg synes det har gått ganske greit egentlig Synes du det? Ja ((Pasienten rister svakt på hodet når hun forklarer videre)) Fordi atte (...) jeg synes at det har vært så vanskelig å få med den medisin (.) tingen med meg hjem Ja Det var så (.) var det verste liksom Å ta ansvar for den selv? Ja
At det er godt når noen doserer og ordner for deg-
Ja
### Model 1. Summary from analysis of videotaped consultations

<table>
<thead>
<tr>
<th>Video no./length min.</th>
<th>Doctor Sex/age/culture</th>
<th>Patient Sex/age/culture</th>
<th>Situation of being understood</th>
<th>Patient interactions observed</th>
<th>Emotions interpreted</th>
<th>*</th>
</tr>
</thead>
<tbody>
<tr>
<td>100/15</td>
<td>Female/30-40/ Norwegian</td>
<td>Female/20s/ foreign background</td>
<td>Patient seems understood. Doctor attentive, caring, empathic</td>
<td>Expresses gratitude and openness toward doctor</td>
<td>Displeasure</td>
<td>Contentment Sentimentality</td>
</tr>
<tr>
<td>129/39</td>
<td>Male/50s/ Norwegian</td>
<td>Male/50s/ Norwegian</td>
<td>Patient does not seem understood. Doctor not attentive of patient’s needs</td>
<td>Justifies his needs and questions</td>
<td>Worry</td>
<td>Embarrassment Frustration Hopelessness</td>
</tr>
<tr>
<td>198/8</td>
<td>Male/40s/ Norwegian</td>
<td>Male/60s/ foreign background</td>
<td>Patient does not seem understood. Doctor asks few questions, seems friendly and distant</td>
<td>Politeness, smile, laughs, silence</td>
<td>Embarrassment</td>
<td>Worry Rejection Insecurity</td>
</tr>
<tr>
<td>300/48</td>
<td>Male/30-40/ Norwegian</td>
<td>Male/50s/ foreign background</td>
<td>Patient seems understood. Doctor attentive of patient, active listening, empathy</td>
<td>Talks openly and freely. Discloses information. Expresses gratitude.</td>
<td>Despair</td>
<td>Suffering Hopelessness Contentment</td>
</tr>
<tr>
<td>371/11</td>
<td>Male/30s/ Norwegian</td>
<td>Male/40s/ foreign background</td>
<td>Patient does not seem understood. Doctor asks questions, but does not follow up</td>
<td>Searches to build alliance with doctor to become understood, uses small talk</td>
<td>Despair</td>
<td>Disappointment Contentment</td>
</tr>
<tr>
<td>378/38</td>
<td>Male/30s/ Norwegian</td>
<td>Female/20-30/ foreign background</td>
<td>Patient seems understood. Doctor attentive of patient, active listening,</td>
<td>Answers doctors’ questions, little initiative to own questions</td>
<td>Mild despair</td>
<td>Sympathy (with baby) Worry</td>
</tr>
<tr>
<td>381/19</td>
<td>Female/40s/ Norwegian</td>
<td>Male/50s/ Norwegian</td>
<td>Patient seems understood. Doctor attentive of patient, asks questions</td>
<td>Talks openly and freely, seeks alliance and understanding</td>
<td>Insecurity</td>
<td>Surprise Worry</td>
</tr>
<tr>
<td>Patient</td>
<td>Gender/Age</td>
<td>Nationality</td>
<td>Interaction</td>
<td>Emotions</td>
<td></td>
<td></td>
</tr>
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</tr>
<tr>
<td>524/11</td>
<td>Male/40s/ Norwegian</td>
<td>Male/70s/ Norwegian</td>
<td>Patient seems understood. Doctor informative, friendly talk</td>
<td>Ask direct questions about concerns, jokes with doctor</td>
<td>Insecurity, Worry, Jolliness</td>
<td></td>
</tr>
<tr>
<td>607/45</td>
<td>Female/50-60/ Foreign background</td>
<td>Male/70s/ Norwegian</td>
<td>Patient seems not understood (misunderstood), doctor friendly but not sincerely understanding</td>
<td>Rhetorical reasoning, explains and justifies, expresses his pain</td>
<td>Tenseness, Anger, Surprise, Irritation, Annoyance, Disappointment</td>
<td></td>
</tr>
<tr>
<td>611/34</td>
<td>Female/30s/ Foreign background</td>
<td>Male/30s/ Foreign background</td>
<td>Patient seems not understood (misunderstood), doctor direct, open and appears intrusive</td>
<td>Disputes directly with doctor, open about frustration and worries, apologizes</td>
<td>Anger, Frustration, Despair, Humiliation</td>
<td></td>
</tr>
<tr>
<td>628/57</td>
<td>Female/30s/ Norwegian</td>
<td>Female/60s/ Norwegian</td>
<td>Patient seems understood. Doctor informative, friendly talk</td>
<td>Appears tough, does not mention concerns, laughs</td>
<td>Worry, Cheerfulness, Contentment, Insecurity</td>
<td></td>
</tr>
<tr>
<td>652/40</td>
<td>Female/40-50/ Foreign background</td>
<td>Male/30s/ Norwegian</td>
<td>Patient seems understood. Doctor informative, empathic and understanding</td>
<td>Takes time, asks questions in a discrete way, open</td>
<td>Worry, Anxiety, Uneasiness, Embarrassment</td>
<td></td>
</tr>
</tbody>
</table>

* Emotion labels taken from model of Shaver et al. (2001).