INTERCULTURAL COMMUNICATION IN HEALTH CARE

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INTERCULTURAL COMMUNICATION IN HEALTH CARE

Non-Swedish physicians in Sweden

Nataliya Berbyuk Lindström

UNIVERSITY OF GOTHENBURG

Department of Linguistics
University of Gothenburg, Sweden
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Abstract

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Author: Nataliya Berbyuk Lindström
Language: English, with Swedish summary
Department: Department of Linguistics, University of Gothenburg, Box 200, SE-405 30 Gothenburg
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This thesis describes and analyzes intercultural communication between non-Swedish physicians and their Swedish patients, as well as communication between non-Swedish physicians and Swedish medical personnel. The focus is on the impact of cultural differences and the use of Swedish as a foreign language by physicians. In addition, the effects of gender and power in physician-patient and physician-colleague communication were investigated.

The thesis is based on a combination of data collection methods (interviews, questionnaires, recordings of naturally occurring medical consultations and staff meetings, and observations) and data analysis (qualitative and quantitative). The goal was to get as complete a picture as possible of intercultural communication in Swedish health care.

The thesis presents a general analysis of communication between non-Swedish physicians and their Swedish patients. This analysis includes the views of non-Swedish physicians, Swedish patients and Swedish personnel about communication, an outline of common problems and how the participants solve them, and an overview of the positive aspects of communication. A particular focus of the thesis is the comparative analysis of some aspects of information seeking (analysis of questions used by the non-Swedish and Swedish physicians and their patients in medical consultations), information giving (use of the pronoun *man* [‘one’] by the Swedish and non-Swedish physicians while providing information to their patients), and acknowledgment and checking (use of repetitions and reformulations for feedback purposes). In addition, an overall comparative analysis of intercultural and Swedish medical consultations was done. Differences and similarities between male and female Swedish and non-Swedish physicians and male and female Swedish patients and personnel are discussed. The power relationship in intercultural medical consultations in which the physician is “weaker” and the patient “stronger” in terms of language competence was analyzed. Furthermore, by comparing “intercultural” communication (between the non-Swedish physicians and Swedish patients) to “monocultural” communication (between Swedish physicians and Swedish patients), some insight into Swedish culture and communication patterns was gained.

The work concludes with some ideas for teaching and training developed on the basis of the findings of the thesis.

KEYWORDS: communication, culture, consultation, physician, patient, language, health care personnel, power, gender

The thesis is written in English.

Interkulturell kommunikation i sjukvården – Utländska läkare i Sverige
Sammanfattning

Avhandlingen analyserar interkulturell kommunikation i interaktion mellan utländska läkare, deras kollegor och patienter i svensk sjukvård. Fokus ligger på hur kulturella skillnader och läkarens användning av svenska som andraspråk påverkar kommunikationen. Maktrelationen mellan läkaren (som är den starkare ur professionell synpunkt men svagare ur språklig och kulturell synpunkt) och patienten analyseras. Dessutom har hänsyn tagits till genus.

En kombination av metoder för datainsamling (intervjuer, enkäter, inspelningar av autentiska medicinska konsultationer, och arbetsmöten samt observationer) och dataanalys (kvalitativ och kvantitativ) har använts i syfte att få en mer komplett bild av interkulturell kommunikation i svensk sjukvård.

Avhandlingens resultat är en beskrivning och analys av kommunikationen mellan utländska läkare och svenska patienter. Bl.a. presenteras utländska läkares, svenska patienters och svensk personals syn på kommunikationen. Dessutom ges en översikt av de mest förekommande problemen, de vanligaste lösningarna på dessa, samt de positiva drag som förekommer i interkulturell kommunikation.

I analysen har speciell hänsyn tagits till vissa aspekter av kommunikationen, nämligen hur läkare och patienter söker information (komparativ analys av frågor i konsultationer med utländska och svenska läkare och deras patienter). Vidare analyseras hur de ger information (särskilt användningen av pronomen *man* (‘one’) hos svenska och utländska läkare), och bekräftar att de har fått (kontrollerar om de har fått) informationen (repetitioner och omformuleringar som återkoppling). I tillägg till detta har en mer generell helhetsanalys av konsultationer med utländska och svenska läkare genomförts.

Avhandlingen avslutas med idéer för undervisning och träning i tvärkulturell kommunikation för sjukvårdspersonal.

NYCKELORD: kommunikation, kultur, konsultation, läkare, patient, språk, sjukvårdspersonal, makt, genus.

Avhandlingen är skriven på engelska.

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Chapter 1: Introduction

1.1 The purpose and the scope of the thesis

The purpose of this PhD thesis is to describe and analyze intercultural communication between non-Swedish physicians and their Swedish patients during medical consultations.

The thesis is one of the outcomes of an interdisciplinary research project with a similar title (i.e., *Kommunikation och interaktion i den mångkulturella sjukvården* ['Communication and Interaction in Multicultural Health Care']) financed by the Forskningsrådet för Arbetsliv och Socialvetenskap (FAS; the Swedish Council for Working Life and Social Research). The project, which took place between 2003 and 2005, was run at the Department of Linguistics and SSKKII[1] in collaboration with Sahlgrenska Akademin (The Sahlgrenska Academy), the University of Gothenburg, and the Västra Götaland region.

The fact that Sweden is rapidly changing from a monocultural society to a multicultural society makes intercultural communication an important issue. Today, meeting a physician who is not Swedish in a Swedish hospital or a health care center is no longer uncommon. In 2007, 62% of all physicians who were granted Swedish medical licenses had been educated outside Sweden; the previous peak was in 2004, when 59% of Swedish medical licenses issued went to physicians whose medical degree was obtained in a country other than Sweden (Fredriksson, 2008). In 2007, the majority of the *utländska läkare* (referred to in this thesis as "non-Swedish physicians") came from Germany and Greece (14% each), Denmark, Romania, Hungary, and Poland. Because their medical licenses are automatically accepted in Sweden under European Union/European Economic Area (EU/EEA) regulations, these physicians are able to start working in Sweden after a short language course (Swedish Medical Association, 2003).

In addition to recruitment from the European countries, a number of support projects have been initiated for physicians in particular and health care personnel in general, among non-European immigrants in Sweden, whose licenses are not automatically approved, as those from the EU/EEA are. Projects such as *Projekt Utländska Läkare* ('Project Foreign Physicians') (Ekström and Oskarsson, 2004), *Legitimation.nu* ('Registered Professions'/ 'Registration.now') (Sahlman et al., 2005) and *Projekt Utländska Legitimationsyrken* ('Project Foreign Registered Professions') in Western Sweden; the Stockholm project (Gellerstedt and Helldén, 2001); and the *Integration legitimationsyrken* ('Integration Registered Professions') project in the Skåne region (Region Skåne, 2005) run between 1999 and 2005 have contributed to making the process of obtaining a Swedish medical license more efficient and less-time consuming for medical personnel from outside the EU/EEA area (see, for example, Andersson, 2006).

Given that non-Swedish physicians make up an increasingly large proportion of the Swedish workforce, the need for well-developed language learning programs and intercultural

1. SSKKII is an acronym made up of the initial letters of the Swedish terms for the following concepts: Language (*Språk*), Semantics (*Semantik*), Cognition (*Kognition*), Communication (*Kommunikation*), Information (*Information*) and Interaction (*Interaktion*).

communication training is obvious. Apart from what are usually recognized as "language difficulties" (e.g., inadequate vocabulary or poor pronunciation), cultural differences can also have a negative effect on communication. They can cause a lack of understanding, misunderstanding, unpredictable emotional reactions and actions, etc., leading to distrust, fear, frustration, misinterpretation of signals and events, self-isolation, and an accumulation of problems (Allwood and Abelar, 1984). At the same time, it should be recognized that cultural differences can have positive effects. Irrespective of the outcome, in order to work effectively, intercultural communication skills and cultural sensitivity are important requisites for non-Swedish physicians as well as for their Swedish colleagues who work with non-Swedish health care workers and patients.

The phenomenon of non-native or foreign physicians is, of course, not limited to Sweden. Foreign physicians are common in many countries, for example, in the USA (Steward, 2003; McMahon, 2004), Australia (Birrell, 2004), the United Kingdom (Swierczynski, 2002; Sandhu, 2005), Canada (Hall et al., 2004), etc. In the above-mentioned countries, the non-native physicians represent between 23 and 28 percent of physicians (Mullan, 2005).

When working in different countries as *international medical graduates/foreign medical graduates (IMG/FMG)* in the United States and Canada, *overseas trained doctors (OTD)* in Australia, *utländska läkare* ('foreign doctors') in Sweden, or *international doctors* in the United Kingdom, foreign physicians experience different but similar problems. These may include differences in professional and doctor-patient relationships (McMahon, 2004); learning new routines; foreign language usage, for example "the need to learn hundreds of new brand names and laboratory values and to adjust to differently formatted medical notes" (McMahon, 2004, p. 2435); understanding dialects, colloquial speech, and body language (Fiscella and Frankel, 2000; Allwood et al., 2004; Allwood et al., 2005; Berbyuk et al., 2006); questioning of the quality of their medical education and the care provided (Fiscella and Frankel, 2000; Allwood et al., 2004; Ko et al., 2005); cultural differences such as being a male physician and having to perform gynecological examinations if one comes from a culture where male physicians do not perform such tasks (Fiscella et al., 1997); changes in lifestyle; sex-role differences; and discrimination and change in status (Fiscella et al., 1997; Allwood et al., 2005). Emotional challenges, such as stress related to the often lengthy process of qualification examinations for training in the new country, fear of rejection and frustration, may be mentioned as well. Intercultural communication is therefore an important issue in today's health care practice and in the education of health care personnel. Analysis of communication between foreign physicians and their patients and colleagues (in our case, Swedish) becomes an important background for training programs, which can minimize the possible negative impact of cultural differences; this in turn can lead to improved health care services. In addition, this analysis may make a valuable contribution to intercultural communication theory and research.

In spite of the increasing number of foreign physicians in different countries around the world, there are few studies that describe their communication with patients and colleagues either in general or from a specifically linguistic viewpoint. As a linguistic study of intercultural communication in health care, this thesis represents an attempt to fill this gap, with two main objectives in view.

As mentioned above, I will focus primarily on communication between non-Swedish physicians and their Swedish patients. However, within the framework of the project this

thesis is based on, a number of studies were carried out on issues related to communication between non-Swedish physicians and their Swedish colleagues. The reader is referred to Berbyuk et al. (2003), Allwood et al. (2004) and Allwood et al. (2005), as well as to Chapter 7 of this thesis, which provides a short summary of the results concerning communication between non-Swedish physicians and Swedish medical personnel.

From an academic perspective, this thesis contributes to the development of the theory of intercultural communication studies and research into health care communication. Health care communication is not a new research area; it has been studied in many different disciplines, such as anthropology, sociology, medicine and linguistics, with each one investigating the physician-patient relationship from different perspectives (see Chapter 2). However, research that involves the physician as a foreigner is rare. The vast majority of studies that investigate the influence of cultural differences on physician-patient communication focus on the more common situation in which the patient is a foreigner. This adds to the novelty of this study.

The other principal aim of this study is a more practical one, namely to help Swedish or non-Swedish physicians, nurses, and assistant nurses, as well as patients who communicate with non-Swedish physicians, to understand and deal with the issues that arise in these situations.

1.2 Specific questions and organization of the thesis

The specific questions addressed by the thesis are presented below.

1. What does communication between non-Swedish physicians and Swedish patients look like? Does it differ from the Swedish way of communication? And if so, how? What kinds of communication phenomena and difficulties are encountered by non-Swedish physicians and their Swedish patients? What linguistic difficulties arise? How do they influence the interaction?
2. What are the positive effects of cultural differences and foreign language use on the process of communication? Do the participants' different approaches or ways of formulating their message sometimes lead to clarifications that are useful for both parties?
3. How are the communicative strategies the physicians use related to the parties' cultural backgrounds, that is, what culture-specific strategies do the non-Swedish physicians who were chosen for the study use when communicating with Swedish patients and how are these strategies related to their cultural backgrounds? In what ways are they different from or similar to the typical Swedish communicative strategies used in a health care environment? Are there communicative strategies that are common to non-Swedish physicians regardless of their cultural backgrounds?
4. The aspect of power relationships in communication: How is the interaction between non-Swedish physicians and Swedish patients influenced when the physician's normally dominant position as a professional runs up against the disadvantage of being a "newcomer" in the patient's language and culture? To what extent does the authority conferred by the role of the professional in the communicative activity compensate for a

lower level of communicative and cultural competence?

5. To what extent is gender a relevant issue in the context of intercultural encounters in the medical environment? Are there certain gender-related strategies that male and female foreign physicians use in communication with their Swedish patients?
6. Do Swedish patients contribute to the language acquisition of non-Swedish physicians? How do they function as "informal teachers"? How does this affect their communication – does it, for example, have an impact on the distribution of power within the interaction?

The thesis is organized as follows. It consists of eight chapters. In this chapter, **Chapter 1, "Introduction**," the purpose of the study was presented and some information about foreign physicians in Sweden and elsewhere was provided, introducing the social background of the thesis. Then the specific questions were raised and the organization of the thesis was outlined.

Chapter 2, "Background," presents some of the basic aspects of intercultural communication both in general and specifically in the field of health care. The chapter constitutes an overview of the fundamental aspects of intercultural physician-patient communication.

Chapter 3, "Methodology and data," discusses the data that provide the basis for the thesis and the methods used to analyze them. A brief overview of the structure of the studies described in the thesis is provided, followed by an outline of data collection methods, participants involved, and data analysis methods.

Chapters 4, **5** and **6** present the results of the study of physician-patient communication.

In **Chapter 7, "Some observations on communication between non-Swedish physicians and their Swedish colleagues**," I present a concise summary of the analysis of non-Swedish physician-Swedish colleague communication. This is followed by **Chapter 8, "Discussion, conclusions, and implications for teaching and training."** Finally, the reference list and a number of appendices appear.

1.3 Some notes about key terms used in the thesis

The terms *doctor* and *physician* will be used more or less interchangeably in the thesis. Since *doctor* is a usually a lay term used by patients, it will be primarily used analyzing data on physician-patient communication. The terms *consultation* and *medical consultation* are used interchangeably, both referring to meetings between physician and patient. *Staff* and *personnel* are used to denote physicians, nurses, assistant nurses, etc., and are used interchangeably as well.

Chapter 2: Background

In this chapter, I provide an overview of the relevant research consulted for this thesis. First, I discuss the issue of intercultural communication, followed by a brief overview of theories related to the topic of this thesis and used for data analysis (2.1). Next, I turn to the studies of medical consultation in general and introduce the reader to the issues that I will focus on in the thesis (sections 2.2. and 2.3 respectively). Separate sections are devoted to discussions of power and gender (2.4 and 2.5). Next, the research on communication between physicians and patients in general and on the intercultural communication between non-native physicians and native patients in particular is presented (2.6). The chapter concludes with a brief overview of studies of Swedish culture and communication patterns (2.7), and a summary showing which areas I have studied and where I will be providing new information (2.8).

2.1 Intercultural communication

This thesis is an intercultural communication study. *Communication*, defined by Jens Allwood (Allwood, 1985) as "the sharing of information between people on different levels of awareness and control" (p. 9) is one of the main prerequisites of human existence. Through communication, we provide and obtain information, create and break relationships, argue and persuade, joke, show our feelings and emotions, etc. Communication implies contact between individuals, achieved by means of language and involving both verbal and non-verbal expressions (e.g., words, gestures, eye contact, facial expressions, etc.).

Communication can be a challenge, even when the participants' backgrounds do not differ very much. However, when communication is *intercultural* (intercultural communication can be defined as communication involving persons with different cultural and linguistic backgrounds), it becomes more of a challenge. *Culture* refers to "all the characteristics common to a particular group of people that are learned and are not given by nature" (Allwood, 1985, p. 10). It is a broad definition, as is Kroeber and Kluckhohn's (1952) definition:

> Culture consists in patterns, explicit and implicit of and for behavior acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiments in artifacts; the essential core of culture consists of traditional (i.e., historically derived and selected) ideas and especially their attached values; culture systems may, on the one hand, be considered as products of action, on the other as conditioning elements of future action.
>
> (Kroeber and Kluckhohn, 1952, p. 181)

There are many other definitions of culture, for example, Hofstede's: "culture is the collective programming of the mind that distinguishes the members of one group or category of people from another" (Hofstede, 2001, p. 9). Lustig and Koester define culture as "a learned set of shared interpretations about beliefs, values, norms and social practices, which affect the behaviors of a relatively large group of people" (Lustig and Koester, 2006, p. 25). All of these definitions focus primarily on ideas and values, and patterns of behavior, excluding tools and artifacts as constituents of culture. Allwood (1985), however, differentiates between four primary cultural dimensions: *patterns of thought*, *patterns of*

behavior, *patterns of artifacts* and *imprints in nature*. These are defined below:

- **Patterns of thought:** common ways of thinking, where thinking includes factual beliefs, values, norms, and emotional attitudes.
- **Patterns of behavior:** common ways of behaving, from ways of speaking to ways of conducting commerce and industry, where the behavior may be intentional/unintentional, aware/unaware or individual/interactive.
- **Patterns of artifacts:** common ways of manufacturing and using material things, from pens to houses (artifact = artificial object), where artifacts include dwellings, tools, machines and media. The artifactual dimension of culture is usually given special attention in museums.
- **Imprints in nature:** the long-lasting imprints left by a group in the natural surroundings, where such imprints include agriculture, trash, roads and intact ruined human habitations. In fact, "culture" in the sense of "cultivation" (i.e., a human transformation of nature) gives us a basic understanding of what the concept of culture is all about.

As Allwood points out, the first two dimensions, patterns of thought and patterns of behavior, are involved in all human activities, while the other two dimensions play a role in some, but not all human activities.

It is not a primary aim of this thesis to critically discuss the concept of culture and its definitions. However, I would like to point out that, by analyzing communication in health care, I will focus on how the patterns of thought and patterns of behavior of non-Swedish physicians and their Swedish patients affect their communication. I prefer a broader, not merely mentalistic, definition of culture (i.e., Kroeber and Kluckhohn's or Allwood's) rather than Hofstede's or Lustig and Koester's. The former are more comprehensive definitions that take into account all aspects of human activities and emphasize culture as being constantly changeable and dynamic, which I see as the essential characteristic to be taken into account in cultural research. Moreover, I am critical of Hofstede's definition as it evokes a picture of culture as something that is rather unconscious, inflexible and fixed, and puts persons who are from different countries in separate groups. In the section below, I will discuss Hofstede's research in more detail, as well as other theories in the field of intercultural communication related to the topic of this thesis.

2.1.1 An overview of relevant theoretical work

Describing and analyzing intercultural communication is an important task today since the world is becoming more globalized. As a research field, intercultural communication is multidisciplinary, comprising contributions from anthropology, psychology, sociology, linguistics, communication studies, etc. The fact that a wide range of issues are discussed and a variety of methods are used for data analysis means that the literature on intercultural communication can be seen as "huge, diverse, without any agreement or any particular unifying focus" (Agar, 1994 as cited in Fitzgerald, 2003, p. 9).

Many studies of intercultural communication are based on the research of Geert Hofstede, who analyzed and compared values in different cultures and created a cultural taxonomy, which provides guidelines for behaviors in different cultures. Although it is widely used, there are a number of weaknesses in Hofstede's research. As I have already mentioned, I consider his definition of culture to be too limited. The fact that his theory uses national borders as cultural boundaries looks rather outdated in today's globalizing world. The methodology he used can also be questioned (number and choice of respondents [the

respondents of Hofstede's questionnaire are only IBM employees, which is a limited population sample], the results are based on averages, which leads to a high degree of abstraction, etc.). For a recent critique of Hofstede's research, see McSweeney (2002) and Søderberg and Holden (2002), as well as Hofstede's replies to the standard criticisms of his approach (Hofstede, 2001, p. 73). Hofstede developed five dimensions of national cultures: *power distance*, *uncertainty avoidance*, *individualism versus collectivism*, *masculinity versus femininity* and *long- versus short-term orientation*. A brief overview of these dimensions is presented below.

The power distance dimension reflects how different cultures deal with human inequality. Hofstede's definition of power distance is as follows: "the extent to which the less powerful members of institutions and organizations within a country expect and accept that power is distributed unequally" (Hofstede, 2001, p. 98). Hofstede also emphasizes that "culture sets the level of power distance at which the tendency of the powerful to maintain or increase power distances and the tendency of the less powerful to reduce them will find their equilibrium" (p. 83). Power distance is reflected in the *Power Distance Index (PDI)*. The higher the index value, the larger the power distance in the society. Examples of relatively high-PDI countries are Malaysia (PDI = 104), Guatemala and Panama (95 each), and the Philippines (94). Countries with a low PDI include Denmark (18) and Sweden and Norway (31 each). According to Hofstede, while the high-PDI countries tend to emphasize hierarchy in society, in the low-PDI countries a flat hierarchy is common, inequality of roles exists for convenience rather than indicating an existential inequality, powerful people should try to look less powerful than they are, subordinates expect to be consulted, and more egalitarian communication between superiors and subordinates, such as bargaining and reasoning, is accepted. The opposite is true for countries with a high PDI.

The second dimension, which Hofstede calls *uncertainty avoidance*, is defined as "the extent to which the members of a culture feel threatened by uncertain or unknown situations" (Hofstede, 2001, p. 161) and measured by the *Uncertainty Avoidance Index (UAI)*. It reflects the level of tolerance for uncertainty and ambiguity within the society and the extent to which people avoid uncertainty by creating laws, rules, regulations, and controls in order to reduce it. According to Hofstede, the representatives of countries with a low UAI, such as Singapore (UAI = 8), Jamaica (13), Hong Kong and Sweden (29 each), and Ireland and Great Britain (35 each) exhibit lower work stress, less anxiety and less hesitation to change employers than the representatives of high-UAI countries, such as Greece (112), Portugal (104), and Guatemala (101). More openness to change and new ideas is observed in low-UAI countries while greater conservatism and a stronger desire for law and order are found in high-UAI countries (p. 160)

The third dimension is i*ndividualism versus collectivism*, which refers to "the relationship between the individual and the collectivity that prevails in a given society" (Hofstede, 2001, p. 209).

According to Hofstede,

> individualism stands for a society in which the ties between individuals are loose: Everyone is expected to look after him/herself and his/her immediate family only. Collectivism stands for a society in which people from birth onwards are integrated into strong, cohesive in-groups, which throughout people's lifetime continue to protect them in exchange for unquestioning loyalty.
>
> (p. 225)

The *Individualism Index (IDV)* measures the degree of individualism in a society. The USA and Australia have the highest IDV (91 and 90 respectively), while Guatemala has the lowest (6). Sweden's IDV is 71. Triandis (1995) also distinguishes between vertical and horizontal attributes of individualism and collectivism (V-H dimension). The vertical dimension emphasizes inequality and privilege, while the horizontal dimension accentuates the similarity of people, especially concerning status. Horizontal individualism is a cultural orientation in which an autonomous self is valued, but any individual is more or less equal in status to others. In the vertical variant of individualism, the self is different from and unequal to others (Triandis, 1995). The latter emphasizes competition and status, and is represented by, for example, the USA, while the former is typical, for example, of Sweden (Daun, 2005). Similarly, in a horizontal collectivist culture, represented, for example, by China, the individual sees himself/herself as a part of an in-group whose members are similar to each other, and equality is valued (one might wonder whether the Chinese are as collectivist today as when Hofstede collected his data, in light of China's economical, political and social changes). Conversely, a vertical collectivist culture, represented by, for example, Japan, emphasizes inequality between group members. I will discuss Swedish individualism (and collectivism) in more detail in section 2.7.

Another dimension is *masculinity versus femininity*, which reflects dominant gender role patterns in society, as measured in the *Masculinity Index (MAS)*. According to Hofstede,

> masculinity stands for a society in which social gender roles are clearly distinct: men are supposed to be assertive, tough, and focused on material success; women are supposed to be more modest, tender, and concerned with the quality of life. Femininity stands for a society in which social gender roles overlap: Both men and women are supposed to be modest, tender, and concerned with the quality of life.
>
> (Hofstede, 2001, p. 297)

The representatives of masculine society value male achievement, control, assertiveness, competitiveness, and materialism while people in feminine societies value nurturing and quality of life and relationships, equality, and solidarity. In more masculine cultures, the degree of gender differentiation is high and sex roles are characterized as inflexible, while the opposite is true in more feminine societies. The highest MAS value is for Japan (95), and the lowest for Sweden (5) and Norway (8).

The fifth dimension of national cultures is *long- versus short-term orientation*, originally called "Confucian dynamism" by Hofstede and Michael H. Bond (Hofstede and Bond, 1988), who developed the survey (Chinese Value Survey) on the results of which this dimension is based. The dimension was added in 1990s after Hofstede acknowledged the Western bias of his other four dimensions, in an attempt to introduce more Eastern (Asian) values. According to Hofstede,

> Long Term Orientation stands for the fostering of virtues oriented towards future rewards, in particular, perseverance and thrift. Its opposite pole, Short Term Orientation, stands for the fostering of virtues related to the past and the present, in particular, respect for tradition, preservation of "face" and fulfilling social obligations.
>
> (Hofstede, 2001, p. 359)

Countries with a high *Long-Term Orientation Index (LTO)* include China (118), Hong Kong (96) and Taiwan (87); countries with a low LTO include Sweden (33), the USA (29) and Canada (23). Persistence, perseverance, thrift, a strong work ethic and respect for a hierarchy of the status of relationships are typical traits of people from high-LTO countries, while expectations of quick results, protection of one's reputation, respect for tradition, a reciprocation of greetings, favors and gifts and less inclination to save are common among representatives of the low-LTO countries.

Apart from Hofstede's research, Edward T. Hall's classic work can be mentioned among the early and significant contributions to the field of intercultural communication (though it cannot really be applied to the analysis of data for this thesis). In 1966, Hall introduced the science of *proxemics* in his book *The hidden dimension* (Hall, 1966), pointing out that people handle space differently and that the use of space is culturally determined. Hall distinguished four *spatial zones (distance ranges)*, namely *intimate*, *personal*, *social* and *public*, that are maintained by people in social situations. Apart from providing a classification of distances for Americans (middle-class adults), he also exemplifies the differences in the use of space in different cultures, such as the USA, England and France. As one can see, Hall differs from Hofstede in remaining closer to observable empirical reality.

Hall also developed the concepts of *high-* and *low-context cultures* and *polychronic versus monochronic time orientation* (Hall, 1981, 1984). Hall claims that cultures differ in the extent to which the environment, more specifically, social context (i.e., the network of social expectations that determine a person's behavior) is meaningful for communication. He divides cultures into *high-context (HC)*, represented by the Japanese, Arab, Latin American, and Mediterranean cultures, and *low-context cultures (LC)*, represented by the Swiss, German, Scandinavian (except Finland, which is an HC culture; see, for example, Lehtonen and Sajavaara, 1985) and North American cultures. HC communication is less verbally explicit; most of the information is either in the physical context or internalized in the person and very little is the coded, explicit, transmitted part of the message. LC communication is the opposite: the mass of information is vested in the explicit code and more reliance on verbal communication is exhibited (Hall, 1981). Most HC cultures are collectivistic while LC cultures tend to be individualistic. Here one can observe an overlap with Hofstede, who claims that Hall's distinction can be considered as an aspect of individualism and collectivism. HC communication fits a collectivist society and LC communication is typical of individualist cultures, as many things that in collectivist cultures are self-evident must be stated explicitly in individualist cultures (Hofstede, 2001, p. 212). Hall's second concept, that of *polychronic versus monochronic time*, reflects the differences in how people use time. The representatives of monochronic cultures do one thing at a time, while people in polychronic cultures tend to perform multiple tasks at one time. It is worth mentioning here that, though Hall's concepts are used in analyzing intercultural communication, it is often complicated to describe a given communication as direct or indirect, implicit or explicit, depending upon the situation. The same applies to time. And whereas Hofstede has statistical data, no such data is

available as a basis for Hall's theory.

In addition to Hofstede and Hall, the research of Trompenaars and Hampden-Turner, which focuses on the analysis of cross-cultural management, should be mentioned. Similarly to Hofstede, Trompenaars and Hampden-Turner (1993, 2002) have developed seven "dimensions of difference" (Trompenaars and Hampden-Turner, 2002, p. 19) to analyze the impact of culture on communication in the business world. These dimensions include *universalism versus particularism* (rule making versus exception finding); *individualism versus communitarianism* (self-interest and personal fulfillment versus group interest and social concern); *specificity versus diffusion* (preference for precise, singular, "hard" standards versus preference for pervasive, patterned "soft" processes); *neutral versus affective* (emotions inhibited versus emotions expressed); *achievement versus ascription* (status determined through success and track record versus status ascribed to a person's potential, for example age, family, education); *inner-directed versus outer-directed* (relationship to environment, control and effective direction from within versus control and effective direction from outside); and *sequential versus synchronous* (views on time, time conceived of as a "race" with passing increments versus time conceived of as a "dance" with circular interactions). One can see that the work of Hofstede, Hall and Trompenaars and Hampden-Turner clearly overlaps. The overlap with Hofstede's research is easy to see. Trompenaars and Hampden-Turner's individualism-communitarianism dimension is similar to Hofstede's individualism-collectivism. Hofstede's uncertainty avoidance is related to people's expressions of emotions, which Trompenaars and Hampden-Turner's neutral versus affective dimension also touches upon. As status and power are related, a similarity can be observed between Hofstede's power distance and Trompenaars and Hampden-Turner's achievement versus ascription dimension. Finally, I see the time concept in Hall's and Trompenaars and Hampden-Turner's research as identical.

Richard Lewis is another researcher whose work is relevant here (Lewis, 2000). Lewis (as he admits himself) relies on the above-mentioned research by Hofstede and Hall; for example, he uses Hofstede's definition of culture as mental programming and Hall's time concept. Lewis classifies cultures into three groups, *linear-active*, *multi-active* and *reactive*, asserting that representatives of different nations demonstrate characteristics from these groups to a higher or lower degree. People in linear-active cultures are task-oriented, highly organized planners, who focus on a schedule and prefer doing one thing at a time, like the Germans, Swedes, Swiss, Americans, and Dutch. Members of multi-active cultures, represented for example, by the Spanish, Mexicans, Portuguese, and Arabs, on the contrary, are loquacious interrelators, who value relationships over timelines, considering reality to be more important than manmade appointments. Basically, Lewis's taxonomy is grounded in views about time in different cultures: polychronic time (= Lewis's multi-active dimension) is typical of collectivistic societies, which generally have less strict attitudes towards time schedules, and monochronic time, which predominates in individualistic cultures (= Lewis linear-active dimension). People in Lewis's third group, namely reactive cultures, represented by the Japanese, Chinese, Taiwanese, Koreans, Turks, Singaporeans and Finns, are characterized as the most introverted; they avoid interrupting, speak in monologues, and concentrate on what is being said. Britons, Turks and Swedes, who, according to Lewis, "fall easily into 'listening mode' on occasion" (Lewis, 2000, p. 42) can also be considered as representatives of reactive cultures.

In Table 1 below, some of the traits of linear-active, multi-active and reactive cultures are presented, which will make it easier to understand their characteristic features:

Table 1: The most common traits of linear-active, multi-active and reactive cultures (from Lewis, 2000, p.41)

Linear-active	**Multi-active**	**Reactive**
introvert	extrovert	introvert
patient	impatient	patient
likes privacy	gregarious	good listener
plans ahead methodologically	plans grand outlines only	looks at general principles
does one thing at a time	does several things at once	reacts
punctual	unpunctual	punctual
sticks to facts	juggles facts	statements are promises
gets information from statistics, reference books, database	gets first-hand (oral) information	uses both
rarely interrupts	interrupts frequently	does not interrupt
separates social and professional	interweaves social and professional	connects social and professional

As we can see, compared to Hofstede, Hall and Trompenaars and Hampden-Turner, Lewis makes more of an attempt to capture communicative characteristics of the representatives of different cultures, in order to provide guidelines for communication. For example, he discusses differences in communicative patterns at meetings, listening habits, etc., of the representatives of different cultures (Lewis, 2000), and even attempts to present them graphically, which is suitable for training (see, for example, Lewis, 1999).

Allwood's approach differs from the parameter approaches discussed above. He uses basic concepts such as work, gender, and hospitality to analyze and compare cultures and takes into consideration, among other things, historical and religious factors, as they help form cultural beliefs and values. For example, discussing attitudes toward work and obligation in Sweden, Allwood (1985) points to the impact of Lutheranism, referring to Max Weber's work *The Protestant ethic and the spirit of capitalism* (Weber, 1958).

Allwood also focuses on the linguistic analysis of interactions themselves more than Hofstede and Lewis. More specifically, he analyzes communication patterns through the study of different social activities, such as physician-patient communication, in which a culture is manifested. In his framework for the study of spoken language communication (Allwood, 1976, 1993b, 2000, 2007a), such factors as activity purpose, roles, overall structures and procedures, which concern typical sequences of events, turn-taking, feedback, spatial arrangements, and topics or what is talked about, are mentioned. In addition, Allwood focuses on the communicative behavior of a single speaker or listener, such as nonverbal behavior, phonological and grammatical patterns, vocabulary, etc. Interpretation and understanding are also constituents of his model, as both are essential for communication to be successful. Understanding consists of processes that connect received information with already stored information, "a major part of which consists of culture specific background information, i.e., beliefs which all persons in a particular cultural community share and take for granted" (Allwood, 1999, p. 93) and thereby place the incoming information in a meaningful context (Allwood and Abelar, 1984). In the context of intercultural communication, in which people with different cultural backgrounds are involved, prejudice and misunderstanding might occur due to participants' lack of awareness of differences in

cultural backgrounds. I will present Allwood's model of activity-based communication analysis in more detail below, discussing research on medical consultation as a social activity (section 2.2).

As one can see, the work of the various researchers discussed above overlaps. For example, such issues as the relationship between the individual and society are examined by all of them. Lewis, as I mentioned above, uses Hofstede's definition of culture as a starting point in his book *When cultures collide: Managing successfully across cultures*. The concept of time is focused on in Hall's, Trompenaars and Hampden-Turner's and Lewis's research. In addition, the data-gathering methodologies on which the analyses are based are similar for Hofstede and Trompenaars and Hampden-Turner, namely questionnaires. One difference is that Lewis and Allwood, being linguists, pay more attention to communication features than Hofstede, Hall, and Trompenaars and Hampden-Turner, who are more focused on the analysis of values. Comparing Lewis and Allwood, Lewis's analysis reflects his experiences when lecturing for trade and industry groups in different countries. He presents a number of brief and concise overviews of different countries, focusing on communication during meetings, superior-subordinate communication, etc., and supporting his analysis with visual presentations. His works are educational aids for managers who need to work cross-culturally. Allwood presents an analytical model for the analysis of intercultural communication in *any* social activity, focusing primarily on Swedish culture, but drawing comparisons with other cultures as well.

As this thesis is a linguistic study of intercultural communication in a specific social activity – medical consultation between physician and patient – I will rely in my analysis primarily on Allwood's framework. When relevant, I will to some extent compare my analysis with the findings of the above-mentioned researchers, as well as the results of other studies mentioned in subsequent chapters, to look for similarities and contradictions.

As mentioned above, not only do cultural differences influence communication in intercultural medical encounters, but foreign language use does as well. A brief overview of the issues that arise in communication between non-native speakers (NNS) and native speakers (NS) is presented in the next section.

2.1.2 Interactions between NNS (non-native speakers) - NS (native speakers)

The interaction between NNS (non-Swedish physicians) and NS (their Swedish patients) falls under the situation defined by Wagner as *foreign language interaction* (i.e., "spoken interaction in which at least one participant uses a language other than his or her native language") (Wagner, 1996, p. 215).

A number of phenomena characterize NNS-NS interaction. They include correction sequences and repairs in case of communication breakdowns (Deen, 1997; Kurhila, 2001), "foreigner talk" (i.e., a subset of linguistic registers involving modified linguistic input to language learners, referring to the speech used when a native speaker addresses a non-fluent non-native speaker-learner) (Ravid et al., 2003), comprehension problems related to non-native speech recognition (Van Compernolle, 2001), simplification, regularization, and elaboration.

This thesis focuses on asymmetry in NS (patient)-NNS (physician) interactions. As pointed

out by Wiberg (2003), "the asymmetry between the NS and the NNS depends on language level reached by the NNS: the more advanced the level, the more likely it is that the NNS will establish a better symmetry in the dialogue" (p. 391). One might suspect that an NNS with lower language competency usually finds himself/herself in a powerless position compared to an NS. However, Deen (1997) stresses the power distribution in the situation, the activity in which a particular interaction occurs, and the speaker's role in it. Deen discusses the study of Woken and Swales (1989), which showed that NNS are not automatically dominated by NS if they are the experts on the topics discussed; in institutional interactions, therefore, expert status has a greater effect on dominance than language proficiency. In medical consultations, it is the physician who is the expert. How does the "expert status" of the non-Swedish physicians combine with their being NNS in interactions with NS?

I will now present an overview of research on physician-patient communication in general, with special emphasis on the research on medical consultation as a social activity and on intercultural physician-patient communication in particular.

2.2 Research on medical consultation as a social activity

Medical consultation is an example of an institutional interaction, "institutional talk" (i.e., an interaction that takes place in an institutional setting) and is "primarily accomplished through the exchange of talk between professionals and lay persons" (Drew and Heritage, 1992, p. 3). The participants in consultation are a professional (a physician) and a layperson (patient). Other participants may also be present, for example, a nurse, assistant nurse, other physician(s), patient's relatives/friends/personal assistants, or an interpreter in case of language difficulties.

As is the case for other types of institutional interaction, communication in the course of consultation has some typical features, namely its purpose, activity structure, typical procedures, physician's, patient's, nurse's and/or relatives' (if present) roles, rights and obligations, artifacts used and the environment in which the interaction takes place. Medical consultation comprises a number of sub-activities or phases, which serve to fulfill the activity's purpose: to provide medical help. Byrne and Long (1976) analyzed about 2000 audiotaped general medical consultations and distinguished the following six phases of consultation: relating to the patient, discovering the reason for attendance, conducting a verbal or physical examination or both, consideration of the patient's conditions, detailing treatment or further investigation and terminating. However, as the researchers themselves admit, it is rare for all six phases to be present in a given consultation. In addition, in different kinds of consultations, some of the above- mentioned phases may be omitted and some are more salient (Kós-Dienes and Allwood, 1991).

Although Allwood does not specifically study medical consultation, he has developed a model for understanding how linguistic communication serves as an instrument of inter-individual coordination (Allwood, 1993b). To study communication in a social activity, it is necessary to combine the requirements of the activity role with the requirements of being a sender or a receiver in communication, as the individuals involved in pursuing the activity's purpose occupy the roles relevant for the activity. They also use tools, one of which is linguistic communication, "the primary instrument of inter-individual coordination in social

activities" (Allwood, 1993b, p. 12). For a more detailed description of the model, I refer to Allwood and Abelar (1984) and Allwood (1985, 1993b). Briefly, communication in social activity is influenced by both the individual backgrounds of the participants and collective activity factors. A simplified version of the model is presented in Table 2 below:

Table 2: Main components of the model of linguistic communication as an instrument of social activity (Allwood, 1993b, p.15)

	Primary non-communicative features	**Primary communicative features**
Individual	Individual background Biological, psychological, social factors	Body movements, phonology, writing, vocabulary, grammar
Interactive	Collective activity factors: -purpose/function -roles -artifacts -environment	Interactional patterns: -sequences -turntaking -feedback -repairs -rhythm -spatial relations

The model presented above illustrates that individual background, consisting of biological, psychological and social factors, and collective factors, including purpose/function, roles, artifacts and environment, influence features and patterns of communication; as well, "communicative contributions influence other communicative contributions and, at least to some degree, individual and collective background factors" (Allwood, 1993b, p. 14). In this thesis, the participants are physicians and patients, whose cultural and linguistic backgrounds differ. How does this affect the communication process? How do the physician and patient, in Allwood's terms, occupy activity-relevant roles and jointly pursue the function or purpose of medical consultation? Are there any differences in the ways non-Swedish and Swedish doctors do their "doctoring" and their respective patients do their "patienting"?

One of the first models of medical consultation, specifically primary care consultation, was developed by David Pendleton (originally presented in Pendleton and Hasler, 1983, and in a revised version in Pendleton et al., 2003). Like Allwood, Pendleton emphasizes the influence of context and the participants' background on communication. As in Allwood's model, the backgrounds of both physician and patient are taken into account. Pendleton mentions values, beliefs and attitudes, skills and experience, and emotional and behavioral factors as influencing the consultation. In addition, he focuses on the immediate, intermediate and long-term outcomes of consultation from both the physician's and the patient's perspectives. Satisfaction with consultation is the desirable outcome for both parties, while change in concern, memory of message, compliance (and other health/illness behaviors), and change in health status apply to the patient.

In this thesis, as mentioned above, I will analyze how the participants' cultural backgrounds influence communication in medical consultation and how medical consultation as a social activity influences participants' communicative patterns. In addition, I will also consider physicians' and patients' satisfaction as an outcome of the interaction.

Below, I discuss in more detail the interactive patterns that are analyzed in the thesis.

2.3 Interactive patterns in medical consultation

In analyzing communication, one should bear in mind that, on the production side, the main purpose is information exchange between participants. This involves **information eliciting** (participants obtaining information from each other) and **information providing** (participants providing information to each other). Furthermore, perception and understanding are essential for a successful communication process. In the course of interaction, it is important for the participants to be sure that the information exchange is functioning well, that nothing is missed or misunderstood. Allwood (1993a) mentions four *basic communicative functions: maintenance of contact and interaction, perception, understanding* and *attitudinal reactions*. These functions necessitate showing understanding and acceptance, as "the least one can demand from a cooperative receiver is that he acknowledges apprehension and understanding, so that the sender has a chance of knowing if he has got his information across" (Allwood, 1976). If it is not clear that the information has been understood correctly, checking is necessary. The failure of the interactant(s) to provide **feedback** (i.e., to acknowledge receiving information and check if the information provided has been heard/understood correctly) might result in lack of understanding/misunderstanding, missing information, uncertainty, stress and anxiety, etc. Asking questions is the most common way to elicit information from the interlocutor and statements are used to provide information. Using feedback is a way to indicate information acknowledgment and verify the information provided.

In a medical consultation, the physician's task is to help the patient to solve health problems and the patient's task is to help the physician to provide this help by offering information that is relevant and adequate. In order to provide adequate medical help, the physician should be able, first of all, to collect necessary and relevant information from the patient; second, on the basis of the received information, and using medical knowledge and professional experience, the physician must make a diagnosis, assign a suitable treatment or direct the patient to the necessary tests, etc. In addition, one of the physician's tasks is to provide information to the patient, for example concerning the disease, preventive health care, etc.

As this thesis focuses on the comparison of communication between non-Swedish physicians, Swedish physicians and their respective patients, I assume that looking at the above-mentioned aspects of communication, namely **how non-Swedish and Swedish physicians elicit information from and provide information to their patients and acknowledge/ check the information received**, might be both useful and interesting. Are there any differences (possibly *cultural* differences) between the non-Swedish and Swedish physicians? Are there differences between the patients of the respective physicians concerning the above-mentioned issues? What are the positive/negative effects of the fact that the physicians come from different linguistic and cultural backgrounds than their patients?

I will look more closely at the issues of information eliciting (questions), information providing, and information acknowledgment and checking (feedback) in the backgrounds to the various sections of this thesis. In addition, I will identify and analyze the instances when communication problems occur, such as lack of understanding/misunderstanding, cultural differences, etc. I will also discuss power, gender and culture in the context of medical consultation.

2.4 Power in physician-patient communication

As in many other social activities, for example, communication in a classroom, business meeting, and so on, the relationship between the participants in a medical consultation is asymmetrical. Due to his/her experience and knowledge, the physician is the one responsible for the interaction, while the patient is a relatively passive participant, whose involvement ranges from simply answering the physician's questions to actively participating in discussions and decision-making. Although the degree of asymmetry in encounters between physician and patient varies (Roter, 2000), it is the physician who has experience and knowledge and who must take responsibility in the interaction and come up with explanations of the patient's problems and possible solutions for them. The issue of power in physician-patient communication during medical consultations is described in more detail below.

I have already mentioned Hofstede's definition of power (p.7). Allwood provides a broader definition:

> A power relationship is said to hold between two or more persons if they can control each other's behavior or thoughts. The relationship is asymmetrical if one or more persons can control the behavior or thoughts of one or more other persons in a certain respect without the latter person(s) being able to control the former person(s) in the same respect.[2]
>
> (Allwood, 1980, p. 2)

The possession of power by one of the participants in an interaction results in an asymmetrical relationship, and communication between physician and patient, as mentioned above, is heavily influenced by this asymmetry. The physician, as a health care provider, is referred to as powerful, and the patient as powerless (Wynn, 1995).

Roter (2000) provides an overview of the prototypes of the physician-patient relationship, such as *paternalism, mutuality, consumerism* and *default*. The first, paternalism, is the most prevalent one, and can be explained as follows:

> In this model of relations, physicians dominate agenda setting, goals, and decision-making in regard to both information and services; the medical condition is defined in biomedical terms and the patient's voice is largely absent. The physicians' obligation is to act in the patient's "best interest." The determination of best interest, however, is largely based on the assumption that patient values and preferences are the same as that of the physician.
>
> (Roter, 2000, p. 7)

Conversely, in the consumerism type of relationship, it is the patient who leads the conversation, sets the goal and agenda of the visit and takes sole responsibility for decision-making:

2. Hofstede's definition is a specific instance of Allwood's definition

> Patient demands for information and technical services are accommodated by a cooperating physician. Patient values are defined and fixed by the patient and unexamined by the physician.
>
> (Roter, 2000, p. 7)

The mutuality type of relationship is characterized by a balance of power between the participants; "the goals, agenda and decisions related to the visit are the results of negotiation between partners; both the patient and the physician become a part of a joint venture. Through this process the physician acts as a counselor or advisor" (p. 7).

Unclear and contested goals, uncertain physician role, and obscure or unclear examination of patient values that can result in a "dysfunctional standstill" are the features of the default type of physician-patient relationship.

Undoubtedly, the power relationship between physician and patient created in a particular consultation depends on a number of factors, such as degree of acquaintance of the participants, as well as culture. For example, it would not be surprising to find that in cultures with a high PDI the relationship between physician and patient is more asymmetrical than in low-PDI countries. The high power distance accepted between physician and patient in Indonesia has its roots in differences in medical knowledge, educational level, and socioeconomic status between physician and patient, combined with a traditional view of the health care provider as authority and such Indonesian values as conflict avoidance and respect. These factors often prevent Indonesian patients from freely expressing disagreement, concern or confusion in communication with heath care providers (Kim Young et al., 2001). The hierarchy that characterizes physician-patient communication in Japan is reflected in physicians not discussing treatment choices in much detail and not explaining procedures to their patients (Ishikawa et al., 2002). Both power distance and collectivism are reflected in Chinese patients' preferences for decision-making concerning treatment: decisions may be made by physicians, jointly, or by the family, but not by the patients alone (Kim Min et al., 1999).

Language is an important instrument for gaining and keeping power in general, and in medical consultations in particular. One of the concepts related to power is dominance, "in principle quantifiable and aggregated patterns emergent over sequences" (Linell and Luckmann, 1991, p. 4).

Linell and Luckmann distinguish four types of dominance: *quantitative dominance* (the number of words the participant uses in comparison to other interactants; the interlocutor who dominates is the one who speaks most); *interactive dominance* (the distribution of initiatives and responses; the dominant interactant is the one who directs and controls the interlocutor's communicative actions more than her/his counterpart, and who at the same time is less controlled in his/her own turns); *semantic dominance* (for instance, who chooses the topic); and *strategic dominance* (outcome-based analysis, focusing on who initiates the strategically most important contributions).

In medical consultation, the research shows that physicians tend to speak more than their patients and prevent them from telling their stories by using closed-ended questions and interruptions (Mishler, 1984). The physicians control interaction by asking questions while the patients answer them (Agar, 1985). Some research has indicated more differences between participants, and some fewer, and a number of influential factors have been

investigated. This topic will be discussed in more depth in Chapters 4 to 6 of this thesis.

2.5 Gender in physician-patient communication

Gender influence on physician-patient communication is another aspect that this thesis touches upon. Research shows that the communication styles of men and women differ. According to Deborah Tannen, women in interaction focus on intimacy, which is defined as "key in a world of connection where individuals negotiate complex networks of friendship, minimize differences, try to reach consensus, and avoid the appearance of superiority, which would highlight differences" (Tannen, 1990, p. 26). On the contrary, men tend to focus on independence, in which "a primary means of establishing status, is to tell others what to do, and taking orders is a marker of low status" (p. 26).

A brief overview of the findings on gender in medical encounters is presented below.

2.5.1 Male and female physicians

Starting with the physician's gender, research shows that, in general, male and female physicians have different styles of communicating with their patients.

Roter and Hall (2004) present a detailed overview of the empirical research on how the physician's gender influences communication. They found that female physicians conduct longer consultations than male physicians, which can be explained by their tendency to initiate partnership building to a greater extent than male physicians (i.e., they actively facilitate patient participation in the medical visit or attempt to equalize status by assuming a less dominant stance within the relationship). In addition, consultations with female physicians include more positive talk, psychosocial counseling, psychosocial question asking, emotionally focused talk and emphatic communication (Bylund and Makoul, 2002; Roter and Hall, 2004) than consultations with male physicians. An exception is obstetrics and gynecology, where male physicians are reported to provide more emotional talk than female physicians (Bylund and Makoul, 2002). Non-verbal behavior differs as well, with female physicians providing more feedback, smiles and nods than their male colleagues. Conversely, male physicians tend to be "more imposing and presumptuous" (giving more advice and paraphrases) and more verbally dominant while female physicians are more attentive and non-directive (giving more subjective and objective information and acknowledgments) (Meeuwesen et al., 1991, p. 1143).

Similarly, Melander Marttala (1996) shows that male physicians have quantitative dominance in interactions (i.e., they produce more words in conversation with their patients compared to female physicians). On the contrary, other studies, for example Skelton and Hobbs (1999a) show no indication of male physicians' verbal dominance. Concerning interactional and semantic dominance (i.e., topic introduction in conversation), though no difference is observed, the male physicians are more likely to introduce medical aspects while female physicians tend to introduce more social aspects in interaction (Melander Marttala, 1996). Male physicians use more formulations, in which they summarize what has been talked about; according to Melander Marttala, this reveals a tendency on the part of male physicians to dominate more in interaction than their female colleagues.

2.5.2 Male and female patients

Concerning the patient's gender, research shows that female patients show more participation in interactions with physicians in general and female physicians in particular (i.e., female-female consultations; patients are more inclined to seek a partnership relationship with female than male physicians) (for an overview, see Roter and Hall, 2004). However, no difference has been found in the number of questions asked by the patients in consultations with female versus male physicians (Roter and Hall, 2004).

Women are more inclined to seek interpersonal relations and have affective reactions to events, while men are more likely to give objective reports of events. This is reflected in female patients' being more inclined to simply discuss their problems with physicians rather than presenting the problems for physicians to solve; females are also more critical of the care provided and tend to change physicians due to communication problems more often than male patients (Elderkin-Thompson and Waitzkin, 1999; Caljouw et al., 2008). Female patients get more time from their physicians and more explanations rephrased from medical terminology in lay terms, which can be tentatively explained by the fact that women provide more detailed histories (Elderkin-Thompson and Waitzkin, 1999). Foss and Sundby (2003) show that female patients are usually more diffuse in their presentation of symptoms, and lack of time is a more common problem for physicians involved in consultations with female patients than with male ones. Wodak (1981) shows that male patients tend to use circumstantial descriptions while women tend to prefer elements from their life history in narrative form. Foss and Sundby (2003) also point out that female patients talk about feelings to a higher degree than male patients. Moreover, the younger female patients (in Norway) were described by the staff as "being able to ask more questions and more aware of their right to be heard" and appeared to be "less willing to listen to the nursing staff" (pp. 47-49). Men are described as reporting more pain and being more frightened than women, but at the same time, male patients are easier to handle (Foss and Sundby, 2003, p. 48). Some studies also report that female patients prefer female physicians (Kerssens et al., 1997, Derose et al., 2001).

2.5.3 Communication in cross-sex and same-sex consultations

Female-female consultations are longer and male-male consultations are shorter than other gender combinations; female-female consultations are also more egalitarian, that is, patient and physician contribution to the dialogue are more equal (for an overview of the research, see Roter and Hall, 2004). The study by van den Brink-Muinen et al. (2002) with a focus on differences in communication patterns in different gender dyads shows that female-female consultations are more psychosocially oriented compared to other gender combinations.

Concerning questioning behavior, it is not surprising that female physicians ask more questions concerning psychosocial issues; however, no clear tendencies concerning question format (i.e., question types) asked by male and female physicians and male and female patients have been found (Roter and Hall, 2004). Interestingly, the study by van den Brink-Muinen et al. (2002), found that, in addition to being longer, female-female consultations included more psychosocial discussion and emotional talk, as well as lower levels of physician verbal dominance; the authors claim that these characteristics of female-female encounters are common across European countries such as the Netherlands, UK, Spain, Belgium, Germany and Switzerland.

Male physicians tend to ask roughly the same number of questions of both male and female patients, while female physicians ask more questions with female than male patients (Ainsworth-Vaughn, 1998). In addition, male patients ask more questions of female physicians than male ones, which supports the above-mentioned assumption that patients are more active in communication with female physicians (Ainsworth-Vaughn, 1998).

To conclude, the research shows that male and female communicative styles differ, and this does have an impact on interaction during medical consultation. However, one should not forget that

> gender is but one of many factors that may correlate with behavior, beliefs, and perceptions. Therefore, researchers should not focus on gender in isolation of other personal (e.g., age, ethnicity, nationality, SES) and situational attributes that also influence health care provider-patient interaction
>
> (Street, 2002, p. 205)

Patients' communication with physicians is also closely related to their age; older patients are more likely than younger ones to accept the traditional asymmetry in doctor-patient power relations and tend to be less involved in decision-making and more satisfied (Haug and Lavin, 1981; Beisecker, 1988; Cline and McKenzie, 1998; Duberstein et al., 2007). Level of education and worry are also factors; for example, more educated patients ask more questions and offer more opinions (Wachtler et al., 2006), while more worried patients express more concerns (Street, 2002). Type of health problems experienced is also an influencing factor (van den Brink-Muinen et al., 2003).

The study by Willems et al. (2005) shows differences related to the patient's socio-economic status and communication; communication with patients from lower social classes is characterized by, among other things, less information giving, fewer directions and fewer socio-emotional and partnership building utterances from the physician. Racial differences may also play a role and influence the information exchange during consultation (e.g.,

Gordon et al., 2006).

Gender is a biological but at the same time a social and cultural construct (Foss and Sundby, 2003). Gender roles in different societies may differ, which can cause additional difficulties in communication between patient and health care provider. In the next section, I present the research on the influence of culture on physician-patient communication in general, and in cases where the physician is a non-native and the patient is a native speaker in particular.

2.6 Culture and physician-patient communication

2.6.1 General overview

Cultural differences and their impact on physician-patient communication have been discussed and analyzed in a vast number of studies. Research into culture and physician-patient communication generally falls into three major categories.

One category includes studies of physician-patient interaction in a particular culture. Examples include the studies mentioned above: Kim Min et al.'s (1999) study on decision-making by Chinese patients, and Kim Young et al.'s (2001) and Ishikawa et al.'s (2002) articles on physician-patient communication in Indonesia and Japan. In addition, research focusing on the analysis of communication with patients with different cultural backgrounds can be mentioned. Scandinavian studies include the studies by Hanssen (2005) for Norway and by Hallingberg and Larsson (1997) for Sweden.

Another category comprises cross-cultural comparative communication studies, which analyze and compare physician-patient relationships in different countries. Many of these studies use a large-scale survey as the data collection method; however, there exceptions (e.g., the already-mentioned study concerning gender and communication in different European countries [van den Brink-Muinen et al., 2002], which uses video-recorded consultations as the basis for analysis). An example of a more qualitative study in this group, which uses recordings of naturally occurring interactions (not arranged ones) between physicians and patients, is the study by Ohtaki et al. (2003). It analyzes differences between American and Japanese physicians interacting with their patients. An example of a survey study, which concerns the scope of end-of-life decisions and attitudes toward advance directives of palliative care patients from the USA, Germany and Japan, is the study by Voltz et al. (1998). The results showed, among other things, that the Japanese respondents were more likely than the American and German respondents to entrust all decisions to the family (known as *omakase*), whereas the American respondents tended to make decisions themselves; the authors explain this result by the influence of cultural factors. Feldman et al. (1999) present differences in ethical standards between American and Chinese internists. US internists were more likely to follow the patient's preferences (emphasis on the rights of the individual – individualism) rather than family preferences when there was a conflict regarding chemotherapy, whereas Chinese internists favored the family's wishes (the role of the family – collectivism). Another example is the Richter et al. (2002) study focusing on the differences between German and Swedish physicians and nurses in performing cardiopulmonary resuscitation (CPR). The German doctors found that they experienced fewer difficulties in their decision-making when no information was available about the patient's wishes, unlike the Swedish ones; the authors explain this as resulting from the hierarchical

structure of the German health care system as well as a more paternalistic attitude of German doctors toward their patients compared to Swedish doctors.

The third category, to which this thesis belongs, comprises analyses of intercultural communication when the physician and patient have different cultural backgrounds. Unlike the studies in the previous two categories, which are mainly based on surveys, studies in this category are more qualitative in nature, smaller in scale, and more likely to use interviews and recordings of interactions, because they focus on issues related to the impact of cultural differences on the interaction itself and on the participants' experiences of it. Some of the themes are differences in physicians' and patients' views of health and illness, for example Lisbeth Sachs' study of Turkish women's communication with Swedish physicians and the differences in their view of the causes of health problems (Sachs, 1983). Differences in patient behavior and involvement in the treatment process, and in their views of health and illness between female patients from Sweden, the former Yugoslavia and Arab countries (Iraq, Palestine, Lebanon, and Egypt) are the focus of Hjelm et al.'s (2003) interview study. Lack of understanding/misunderstanding, culture and foreign language use in consultations are discussed by Roberts et al. (2005). I also include in this category studies that analyze interactions between physicians and patients with different cultural and linguistic backgrounds, who communicate with an interpreter's help (e.g., Davidson, 2001; Flores et al., 2003).

The results of all the above-mentioned studies show that cultural differences and language problems appear to be obstacles to interaction. To the best of my knowledge, there has not been a single study on intercultural physician-patient communication that has highlighted a *positive* rather than a *negative* influence coming from the use of foreign language and cultural differences in participants' backgrounds. However, in the field of intercultural communication in general, although the prevailing tendency is to see cultural differences as an obstacle to communication, a number of researchers have attempted to find the benefits of diversity (e.g., Søderberg and Holden, 2002). It would be interesting to find out whether there are any positive sides of diversity in a health care context that may arise when a health care provider is a foreigner. In addition, it would also be interesting to analyze what the power relationship looks like when the physician's power as a health care provider is combined with his/her uncertainty with language.

2.6.2 Intercultural communication between a foreign physician and a native patient

What does the interaction look like when it is the physician, not the patient, who is a foreigner and the patient is a native speaker? Similar to any other foreigner and second-language speaker, a foreign physician might be singled out by appearance, "strange" name, accent, and body communication, as well as cultural differences in values, beliefs and norms, such as conflict resolution, expressing feelings, temperament, and attitudes, beliefs and standards that differ from the host society's. Coming to another country and being a foreigner often implies striving to achieve status and a place in society and learning a new language and culture. In addition, one's professional competence is often questioned, especially when one comes from a less developed country to a more developed one.

Communication between foreign physicians and their patients has not received much attention in spite of the fact that migration of health care personnel is not uncommon (Stilwell

et al., 2004). In Table 3, I provide a concise summary of the issues related to intercultural communication between a foreign physician and a native patient.

Table 3: An overview of studies of issues related to communication between a foreign physician and a native patient

Issues	**Study/Country**
Credential issues *e.g., lack of visa, etc.*	(Horvath, Coluccio, Foy, & Pellegrini, 2004)/USA
Working in rural areas, treatment of patients with lower social status, to "fill in" gaps due to physician shortages	(Howard et al., 2006)/USA
Inadequate level of medical/surgical knowledge	(Horvath et al., 2004)/USA
Language problems	
• **Spoken language**	
understanding regional patient dialects	(Fiscella et al., 1997)/USA (Fiscella & Frankel, 2000)/USA (Swierczynski, 2002)/Great Britain (Steward, 2003)/USA (McMahon, 2004)//USA (Hall et al., 2004)/USA (Horvath et al., 2004)/USA (Lockyer, Hofmeister, Crutcher, Klein, & Fidler, 2007)/Canada
understanding and usage of colloquial speech	
use of common language rather than medical jargon	
bodily communication e.g., *understanding non-verbal signals, eye contact*	
speech inflection	
physician's accent	
difficulties learning and using medical vocabulary, brand names, abbreviations in target language, *e.g., DOA: dead on arrival*	
difficulties providing emotional support to patient, express caring and concern, both verbally and non-verbally *e.g., touching patient for support; "Patients and relatives thought that I did not care much"*	
difficulties in giving and accepting feedback	
misunderstanding due language problems	
• **Written language** *e.g., Problems with reading and writing, incompleteness of notes, problems with understanding*	(Hall et al., 2004)/USA
Emotional challenges, feelings of acceptance/rejection, discrimination	
discrimination on basis of language competence, race, etc, *e.g., "I don't want any doc who can't speak English taking care of me"*	(Fiscella & Frankel, 2000)/USA (Moore & Rhodenbaugh, 2002)/USA (McMahon, 2004)/USA (Srivastava & Green, 2004)/Australia (Hall et al., 2004)/USA (Srivastava & Green, 2004)/Australia (Coombs & King, 2005)/USA (Ko et al., 2005)/Canada
"fear of patient bias" (patients' suspicion about physician's medical competence) on basis of language competence, IMG (international medical graduate) status *e.g., analysis of risk-adjusted mortality rates and adjusted use of secondary prevention medications of patients treated by IMG vs. Canadian medical graduates; no difference was found* (Ko et al., 2005) staff discrimination against IMG	
discrimination on basis of appearance, clothes, etc.	
being singled out, constant pressure to perform and not to show any weaknesses *e.g., "Being a foreigner, I may be punished if I make a small mistake"*	
Lack of knowledge concerning the host society in general and host health care system (differences in procedures) and technology (equipment, computer skills, etc), physician's rights and obligations in particular	(McMahon, 2004)/USA (Hall et al., 2004)/USA (Horvath et al., 2004)/USA (Allan, Manca, Szafran, & Korownyk, 2007)/Canada (Lockyer et al., 2007)/Canada

Influence of cultural background on consultation procedure and treatment	
performing physical examination, other medical procedures *e.g., ability to perform gynecological examination, (male physician performing examination on female patient), more/ less procedures than in home country*	(Fiscella & Frankel, 2000)/USA (Lockyer et al., 2007)//Canada
different physician-patient/physician-personnel roles based on cultural differences, change in status, *e.g., patient questions the physician*	(Erickson & Rittenberg, 1987)/USA (McMahon, 2004)/USA (Narasimhan, Ranchord, & Weatherall, 2006)/New Zealand (Lockyer et al., 2007)/Canada (Pilotto, Duncan, & Anderson-Wurf, 2007)/Australia
differences in patients' expectations concerning physician and treatment *e.g., higher or lower expectations of the doctor in the host country compared to physician's home country, negotiating treatment plans, disclosure of medical information to patient vs. family, attitudes and values e.g., hierarchy, role of elderly, taboos, more knowledgeable patients compared to patients from physician's home country*	(Educational Commission for Foreign Medical Graduates, 1976)/USA (Hall et al., 2004)/USA (Hirsch-Moverman et al., 2006)/USA (Horvath et al., 2004)/USA (McMahon, 2004)/USA (Kales et al., 2006)/USA (Lockyer et al., 2007)/Canada
physician's tendency not to ask for more information, clarification, will not disagree with or question attending MD	
lack of acceptance of deficiencies and inability to accept constructive criticism	
forms of address	
religion	
time issues e.g., poor time management and multitasking techniques, being on time	
gender issues	
differences in disease panorama in home and host country, physician's view of health and illness	
Patients as teachers *e.g., give feedback, help with language, a resource for learning*	(Allwood et al., 2004)/Sweden (Berbyuk et al., 2006)/Sweden (Allwood & Berbyuk, 2006)/Sweden (Lockyer et al., 2007)/Canada
Differences in physical environment *e.g., one-bed/two-bed room vs communal wards*	(McMahon, 2004)/USA

As one can see from the summary in Table 3, the majority of studies are based on data from the USA, Canada, Australia, New Zealand and Great Britain. Non-Swedish physicians' communication with patients and colleagues in Sweden is primarily represented by the articles written by the research group connected with my Ph.D. project. Among the problems experienced in communication with patients, lack of medical knowledge and language and cultural problems are mentioned. Lack of knowledge about the host country is also mentioned. No study mentions the positive side(s) of communication between non-native physicians and native patients.

Methodological issues should be considered as well. Few studies – in fact, only the article by Erickson and Rittenberg (1987) and the articles from the above-mentioned project – use recordings of actual interactions; other studies use primarily interviews and questionnaires (with the exception of Fiscella and Frankel, 2000, who used critical incidents and focus groups). This means that few examples of language problems from actual interactions are available; only participants' views of problems are presented.

This thesis combines recordings of medical consultations, questionnaires and interviews in an attempt to provide examples of actual interactions together with participants' views concerning their communication. The methodology of the study is described at greater length

in Chapter 3.

2.7 Some remarks about Swedish culture and health care

In spite of the fact that representatives of more than 20 cultures provide the material this thesis is based on, all of them have to handle one culture, namely Swedish culture. Therefore, although I have already mentioned some characteristics of Swedish culture in the sections above, it is beneficial to present a concise overview of the research on Swedish culture and communicative patterns in order to get a better understanding of the results of this study. The overview comprises the research of Hofstede, Lewis, and Trompenaars and Hampden-Turner, as well as studies that focus exclusively on Swedish culture, such as Phillips-Martinsson (1992), Allwood (1985, 1999), Daun (1996, 2005) and Herlitz (2003).

Hofstede assigns a relatively high score on individualism to Sweden, claiming it to be an individualistic culture, which is true but not the whole truth. Seeing Sweden as an individualistic country provides a simplified and incomplete picture. On one hand, Sweden is an individualistic country. However, Swedish individualism, in Hampden-Turner and Trompenaar's terms "has a very different quality" (Hampden-Turner and Trompenaars, 1993, p. 235), compared to, for example, the United States. As I have mentioned, in Triandis' terms, Swedish individualism is horizontal (i.e., an autonomous self is valued, but each individual is more or less equal in status to others); that contrasts to the vertical individualism, which emphasizes inequality and privilege, typical, for example, of the USA (Triandis, 1995). Individualism in Swedish society is reflected in the common sayings *den gode mannen reder sig själv* ('a good man manages himself') and *du gör som du vill* ('do what you want to do'), which emphasize individual rights and autonomy.

Swedes make a clear distinction between private and public life. This difference, Allwood (1999) claims, is more strictly upheld than in many other countries, and is rooted in Martin Luther's doctrine of a distinction between *Person und Amt* ('personal life and official duty'). It is relatively uncommon for friends at work to be friends in private life, which often makes it difficult for foreigners to develop private friendships with Swedes (Allwood, 1999; also pointed out by Phillips-Martinsson, 1992).

On the other hand, there are also collectivistic trends in Swedish society. Collectivism is reflected in national movements, participation in organizations that involve individuals with similar points of view and interests, and conformity, that is, not standing out (Daun, 2005). Daun (1996) emphasizes the Swedish striving for sameness and conformity and intolerance of dissimilarities, rooted in *Jantelagen* ('the Jante law') and reflected in a negative view of boasting and positive view of shyness, striving for consensus, and avoiding direct confrontation. Talking quietly, avoiding raising one's voice and not making eye contact are some of the behavior traits that cause Swedes to be seen as modest and shy. In addition, the importance the Swedes place on what is said and how (*Vad vi säger tolkas som tecken på vem vi är* ['What you say is the sign of what you are']) results in Swedes being seen as more reserved and less talkative than the representatives of other cultures. Daun also relates shyness and modesty to the Swedish negative view of aggressiveness and positive view of conflict avoidance, which is reflected in an indirect communication style and a low pitch in interaction, uneasiness about interruptions and view of silence as a time for speculation and

not as a lack of interest in interaction. Saying *nja* or *nä* instead of a more direct *nej* ('no') is also a strategy to avoid confrontation (Herlitz, 2003). Daun also cites Allwood (1999), who mentions that the Swedish intensive use of the feedback word *jaa* and saying *tack* ('thank you') are signs of "consensus making behavior." Being honest is also one of the traits of the Swedish character. Daun points out that

> the desire not to lie stands counter to the desire to achieve mutual understanding. The opposition is dissolved through silence and the selective avoidance of sensitive subjects. What one says is true, honest, but need not be the whole truth.
>
> (Daun, 1996, p. 98)

It is worth paying special attention to Swedish decision-making. The Swedes see a decision as a solemn agreement between the participants at the meeting. Each person has the opportunity to make concessions, and a collective agreement on a decision, not one person's decision, is important. Lewis (2000) points to the similarities in the collectivistic form of Swedish and Japanese decision-making, where everyone has "ample opportunity to discuss projects thoroughly, since the right to debate and express one's opinion is paid for by strict adherence to the company policy once it has been settled" (p. 283). This also illustrates the collectivistic trend in Swedish society.

Concerning power distance, Sweden has a relatively low score in Hofstede's study, which implies a comparatively small power distance between superior and subordinate. A Swedish leader often functions as an advisor, rather than an authority, and subordinates are used to taking the initiative. Hampden-Turner and Trompenaars point to Swedish managers' willingness to "delegate authority" and equality. The tendency to make collective decisions rather than decisions on one's own authority (which can be linked to Swedish collectivism) is clearly present.

Swedes value facts and concrete information. The Swedes, as mentioned above, are representatives of monochronic and linear-active cultures in Hall's and Lewis's terms; logical argumentation, factualness, and matter-of-factness are common means of persuasion while the expression of emotions is rare (Daun, 1996; Herlitz, 2003). Punctuality should also be mentioned here. The short power distance in Swedish society, as well as equality in gender roles and desire for a proper consensus, are reflected in a democratic way of communication during meetings and active listening using much verbal feedback. Informality, addressing the superior as *du* (Eng. 'you', informal) (see Allwood, 1999, for a history of the change in forms of address), and not using titles are widely accepted.

Sweden is also rated as the most "feminine" country in Hofstede's study. Quality of life, valuing interpersonal aspects, physical environment, nurturance and equality between sexes are emphasized (Lewis, 2000).

Few studies describe communication between physicians and patients in Sweden. Daun (1996) mentions the by of Hendin (1964), who describes Swedish female patients as being more reserved than Danish ones, which Daun relates to the Swedish shyness. I have already mentioned Richter et al. (2002), which describes Swedish medical personnel as striving for consensus and a shorter power distance compared to the German physicians. Short power distance and consensus imply that the physician usually functions as an advisor, who in the course of a rather informal interaction involves the patient in the decision-making process (*samråd*). The patient in his/her turn is expected to take an active part in his/her own

treatment. The patient's making decisions about his/her own health is favored (Herlitz, 2003). In addition, the articles written within the project mentioned above (see Table 3) provide a more detailed overview of Swedish patterns of communication in medical consultation. Such characteristics of the Swedish patients as being demanding and well prepared, curious and helpful with language problems in terms of assisting in finding the right word, repeating what was said, talking slower and guessing what the physician means have been mentioned. In addition, consultations are experienced as being more informal than consultations in the non-Swedish physicians' home countries. Swedish tolerance and patience as well as conflict avoidance were also mentioned by the non-Swedish physicians.

In this thesis, I will go more deeply into the issues mentioned in the articles and combine the findings of the interviews, questionnaires and observations with the analysis of recordings of medical consultations to find answers to the specific questions raised in this thesis. In analyzing communication between non-Swedish physicians and their Swedish patients and comparing it to the communication between Swedish physicians and their Swedish patients, I will examine how the non-Swedish physicians and their Swedish patients fulfill their roles in intercultural medical consultations and how cultural differences influence interaction during consultation, such as physicians' and patients' views of power distance and relationship in consultation, the influence of collectivism/individualism, gender roles and culture, etc. I will also compare intercultural and Swedish medical consultations. In addition, because the focus is on NNS-NS interaction, the strategies the non-Swedish physicians use to communicate with their Swedish patients and vice versa will be discussed. Finally, I will specifically look at the positive aspects of intercultural medical consultations.

2.8 Summary of Chapter 2

In this chapter, I provided an overview of the research relevant to the topic of this thesis, which includes research on medical consultation as a social activity, intercultural communication and native speaker–non-native speaker interaction, issues of gender, power and culture in consultation, as well as an overview of some of the cultural traits of Swedish communication. To sum up, in this thesis, communication between physicians and patients with different linguistic and cultural backgrounds will be analyzed based on Allwood's activity based communication analysis. Secondly, I will compare my findings with the findings of the studies mentioned above to see whether my data confirm or contradict what has been done in previous research, and why. I will provide a general analysis of the participants' views on communication, problems and positive experiences. In addition, I will focus on issues of information getting (questions), information giving and information acknowledgment and checking (feedback). I will provide a more detailed background on these issues in subsequent chapters. Issues of understanding will be addressed as well, and gender and power will be analyzed.

Chapter 3: Methodology and data

This chapter presents the data collection and data analysis methods that I have used in this thesis. It also describes what types of data were collected. Different methods of data collection (interviews, observations, questionnaires and recordings of interactions) and data analysis (qualitative and quantitative) have been combined in the thesis. The analysis of the transcribed recordings of medical consultations, both qualitative and quantitative, has been combined with an analysis of the interviews, questionnaires and observations. Below, I begin with a general overview of the structure of the research and studies carried out for the thesis (3.1). Next, I present information about the data collection methods and the data collected (3.2), the participants (3.3) and some remarks on the data collection process (3.4). Data analysis methods are outlined in section 3.5, followed by a short section about translation (3.6). I conclude with a short summary of this chapter (3.7).

3.1 Overview of the research structure and studies carried out

The data for this thesis were collected and analyzed within the framework of Activity Based Communication Analysis (ACA). The main claim of this theory, developed by Allwood (1976, 1993a, 2000, 2007a), is that linguistic communication does not occur in vacuum but in an activity, such as physician-patient consultation, and therefore communication should be analyzed in relation to the social activity in which it occurs. As an empirically grounded type of linguistics, ACA is based primarily on recordings of authentic linguistic interaction. Recordings of multimodal, direct, face-to-face communication, like the ones I have made of medical consultations, constitute the preferred method of data collection. Such recordings may be combined with interviews and questionnaires, as has been done in this study. Collecting large amounts of data, transcribing recordings and making corpora to capture statistically significant patterns using both computer-supported analysis of an automatic or semiautomatic kind and more qualitative analysis are emphasized. In spite of the limitations that result from being just a small collection of certain types of language use, a corpus is still a source of robust and realistic data that is relatively independent of prejudice, normative beliefs and limitations of the linguists' semantic-pragmatic imagination. Because ACA aims to describe, analyze and explain linguistic interaction in as "naturalistic" circumstances as possible, the data obtained should have "ecological validity," that is, they should deal with phenomena that are robust, independently of the researcher's control and manipulations (Allwood, 2007a).

In this thesis, a procedure that respects the above-mentioned aims of ACA, presented in Allwood (2007a), has been followed, as described below.

First, **identification of a particular social activity type** (or a set of related social activity types) for the study takes place, on the basis of analysis of the activity's purpose, function and procedures, and participants' rights, obligations and competences, as well as the use of artifacts and the environment in which the interaction takes place. In our case, the activity is medical consultation.

Second, there is **a process of data collection and analysis**. The data collection methods used in this study are interviews, questionnaires, video/audio recordings of medical consultations

and participant observation. In Table 4 below, a general overview of the data used in the thesis is presented. Concerning the recordings of consultations, two sub-studies were initiated, the ICCMedConsult (Intercultural Medical Consultation) Study and the SweMedConsult (Swedish Medical Consultation) Study. The former involves the recording of interactions between non-Swedish physicians and their Swedish patients, and the latter recordings of Swedish physicians communicating with Swedish patients. The SweMedConsult Study is a reference study; the reference group idea makes it possible to analyze both differences and similarities in the non-Swedish and Swedish physicians' communication patterns and those of their respective patients.

Table 4: General overview of data used in the thesis

Data collection methods	**Amount of data**
Interviews	51
Questionnaires	277
Recordings of medical consultations	63
ICCMedconsult (Intercultural Medical Consultation) Study	*34*
SweMedConsult (Swedish Medical Consultation) Study	*29*
Observations	10

Five categories of participants, "non-Swedish physicians," "Swedish physicians," "other Swedish health care personnel" (Swedish health care staff other than physicians), "other non-Swedish health care personnel" (non-Swedish health care staff other than physicians) and "Swedish patients" were involved in the project. The subsequent sections provide more detailed descriptions of the data collection methods and procedures, the data and the participants.

Concerning **data analysis**, I have made an attempt to combine the analysis of data obtained using the above-mentioned data collection methods in order to obtain a very complete picture of communication and find at least partial answers to the specific questions posed in this thesis. While the analysis of interviews and the questionnaires provide information about the respondent's attitudes and views on communication, the recordings of medical consultations and the observations are sources of data on what happens in actual interactions in terms of participants' communicative behavior.

A qualitative approach was used in the analysis of the interviews, observations, recordings of medical consultations and comments in response to the questions asked in the questionnaires. A quantitative approach was applied in the analysis of the questionnaires (the number of responses obtained) and of the recordings of medical consultations (frequency of occurrence of a given phenomenon in the interaction, e.g., certain question types, word frequencies, number of pauses, vocabulary richness, etc.).

3.2 Data collection methods

Below, brief outlines of the data collection methods used are presented.

3.2.1 Interviews

Semi-structured interviews were conducted with all five participant categories. The physicians were interviewed before and/or after recordings of medical consultations and the other health care personnel – during or after observation sessions. Swedish patients were interviewed and the questionnaire administered, after the patient had filled in the form.

The interview procedure, roughly similar for all the participant groups, was as follows.

First, the interviewer became acquainted with the interviewee and explained the interview's purpose. Then, the interviewee was asked to provide some background information including age, education and working experience (both in the home country and in Sweden for the non-Swedish physicians and other non-Swedish health care personnel)[3]. In the case of patients, because the interviewee's background information had already been provided in the questionnaire, the questions about background were omitted, which explains the comparatively short interview duration with the patients compared to the ones with the other participant groups (see Table 5 below).

Next, in the interviews with the physicians and other health care personnel, the questions related to the interviewee's experience of communication with Swedish patients and the comparison to the patients in the interviewee's home country (for the non-Swedish physicians and other non-Swedish health care personnel only) were asked. The Swedish physicians and other Swedish health care personnel were also interviewed about their views of communication between non-Swedish physicians and Swedish patients.

In the interviews with the Swedish patients, the patients were asked to comment on their experience of communication with one non-Swedish physician of their choice, be it the one they had met most recently, the one they remembered best, etc. In addition, the patients were asked to discuss and compare their communication with the non-Swedish physician and the Swedish physicians they had met.

Last but not least, all the participants were encouraged to comment on the interview questions and to add any information they considered to be missing at the end of the interview.

An overview of the interview data is presented in Table 5. Audio-recordings or field notes were used for data recording with the interviewee's consent.

3. The interview questions are similar to the questions in the questionnaires, which are presented in Appendix A.

Table 5: Overview of the interview data

Participant category	Number of interviews/registration method		Recording time	Mean recording time
	Audio recordings	Field notes		
Non-Swedish physicians	17	3	9 hrs 18 min	32.8 min
Swedish physicians	3	0	1 hrs 36 min	32 min
other Swedish health care personnel	5	0	1 hrs 12 min	14.4 min
other non-Swedish health care personnel	8	0	4 hrs 36 min	34.5 min
Swedish patients	5	10	0 hrs 47 min	9.4 min
Total: 51 interviews; total recording time: 17 hrs 48 min; mean interview time: 28 min				

3.2.2 Questionnaires

Three questionnaires, one for the non-Swedish physicians, one for the Swedish physicians and other Swedish health care personnel[4], and one for the Swedish patients, were used to get a more representative sample of the aspects mentioned in the interviews. No questionnaire was administered to other non-Swedish health care personnel.

The structures of the questionnaires for the non-Swedish physicians and the Swedish physicians and other Swedish health care personnel were similar to the interview structure outlined above (i.e., a section on background, followed by sections on physician-patient communication and physician-health care personnel communication). Similar to the interviews, in the questionnaires for Swedish patients, the introductory section was followed by questions concerning the patient's experience of communication with one non-Swedish physician they had encountered. In addition, patients were asked to compare their experiences of communication with non-Swedish and Swedish physicians. All three questionnaires included space for the participants to write their comments and/or to provide additional information after each question.

In the three questionnaires, there were 39 questions for non-Swedish physicians, 23 for Swedish health care personnel, and 30 for Swedish patients. There were three types of questions (i.e., closed-ended, open-ended, and multiple-choice). For this thesis, selected questions have been chosen. The criteria for selection were the relevance to the purpose of the study and the response rate. For the questionnaires and the cover letter (in Swedish), see Appendix A.

Concerning distribution, the questionnaires for the non-Swedish physicians were sent by regular mail and in some cases by e-mail to the addresses provided by the Region Västra Götaland, as well as by personal communication. The questionnaires for the Swedish physicians and other Swedish health care personnel and the Swedish patients were distributed in health care institutions by project assistants with the management's consent. Only the questionnaires that were completely filled in were selected for the study. An overview of the questionnaire data is presented in Table 6 below.

4. The same questionnaire was sent to Swedish physicians and other Swedish health care personnel.

Table 6: Overview of the questionnaire data

Participant category	Number of questionnaires
Non-Swedish physicians	85
Swedish physicians and other Swedish health care personnel	108
Swedish patients	84
Total: 277 questionnaires	

3.2.3 Recordings of medical consultations

Nurse: nu har ja spärrat för så de syns inget
Nurse: now I have blocked it so that nothing is seen
(nurse comments to the patient about putting the lock on the video camera lens before the physical examination)

Patient: de gör inget ja brukar gå vara på såna ställen där < de inte behövs kläder>
Patient: it doesn't matter I usually go to places where one < doesn't need clothes >
@ < laughter: nurse >
EXCERPT from the transcription

The physicians, Swedish and non-Swedish, were contacted and then given personally and/or sent a short project description by regular mail or e-mail inviting them to participate in the project. Upon the physicians' agreement, and before the consultation, their patients were informed verbally about the project by the research assistant(s) and physician/nurse (if present) and asked to participate. The patients who agreed signed the consent form for video recording (see Appendix B) before the consultation was recorded. The consultation was only recorded if both the patient and any other people present at the consultation, such as the patient's relatives, caretakers, friends, etc., agreed to participate, signed the form and/or gave their verbal agreement (in case of writing difficulties). If the patient refused to participate, the camera was not turned on.

The consent form was written in Swedish, because only Swedish patients were selected for the study. The research assistant(s) talked to the participating physicians about the patients on the list before consulting hours. Only patients of Swedish origin (judging from the name(s) and information obtained from physicians) were selected. In addition, the research assistant(s) and the physicians agreed which patients should not be asked to participate for various reasons, for example, the nature of the patient's problem or the high sensitivity of the problem to be discussed.

One might speculate whether the fact that the participants were aware of being recorded might have resulted in unnatural behavior. Although some studies show a low or even no effect of the presence of a video camera on physicians' (Pringle and Stewart-Evans, 1990) and patients' behavior (Martin and Martin, 1984; Coleman, 2000), a number of steps were taken in this project to minimize the possible effect of video recording on participants' behavior. First, the camera was placed outside the participants' field of vision. Second, the research assistant(s) were not present during the recordings. Third, upon agreement with the physician and/or nurse, they took responsibility for covering the camera lens when necessary (see above), which minimized interruptions of the interaction.

Non-Swedish and Swedish physicians communicating with Swedish patients during medical consultations were recorded within the ICCMedconsult (Intercultural Medical Consultation) Study and the SweMedConsult (Swedish Medical Consultation) Study, respectively. The recordings of the ICCMedconsult study are subdivided into three groups according to the

non-Swedish physicians' countries of origin, namely the Hungarian, Iranian and Mixed groups. The latter includes the recordings of medical consultations in which physicians from different cultural backgrounds were involved (for a more detailed overview of the non-Swedish physicians who participated in recordings of consultations see section 3.3). A general overview of the recordings is provided in Table 7 below. A detailed overview of the recordings is presented in Appendix C.

Table 7: Overview of the recordings of medical consultations

Study/cultural group	**Number of recordings**			**Recording time**		**Mean recording time**
	video	**audio**	**total**	**video**	**audio**	
ICCMedconsult Study	31	3	**34**	8 hrs 5 min[5]	0 hrs 42 min	15.5 min
Hungarian group	*11*	*1*	***12***	*2 hrs 5 min*	*0 hrs 29 min*	*12.8 min*
Iranian group	*13*	*2*	***15***	*3 hrs 5 min*	*0 hrs 13 min*	*13.2 min*
Mixed group	*7*	*0*	***7***	*2 hrs 55 min*	*0*	*25 min*
SweMedConsult Study	15	14	**29**	3 hrs 19 min	2 hrs 44 min	12.5 min
Subtotal ICCMedConsult and SweMedConsult	46	17	**63**	11 hrs 24 min	3 hrs 26 min	14 min
Total: 63 recordings; total recording time: 14 hrs 50 min, mean recording time: 14 min						

To start with the ICCMedConsult Study, all the recordings were made within the "Communication and Interaction in Multicultural Health Care" project. In total, 34 recordings, 31 video and 3 audio, were used for this study.[6] The recordings of ICCMedConsult Study comprise 12 recordings in which Hungarian physicians were involved, 15 with Iranian physicians and 7 with physicians of the so-called "Mixed group," which included physicians from the former USSR (Russia), Germany, Colombia and the former Yugoslavia.

Concerning the SweMedConsult study, a total of 29 recordings were analyzed, 15 of which (video-recordings) were made within the above-mentioned project; 14 transcribed audio-recordings of interactions between Swedish physicians and their Swedish patients were taken from the database of the previous research project on physician-patient interaction "Communication in Health Care with Regard to Drug Prescription" (Kós-Dienes and Allwood, 1991) run at the Department of Linguistics, University of Gothenburg.

The physicians involved had a wide range of specialties (see section 3.3). This resulted in a variety of consultation types.

5. The numbers have been rounded.

6. It is worth mentioning here that a total of 91 consultations were recorded within the "Communication and Interaction in Multicultural Health Care" project; 49 of them were selected for analysis (34 for the ICCMedconsult Study and 15 for the SweMedConsult Study). The criteria for exclusion were poor recording quality and/or incompleteness.

3.2.4 Observations

I conducted 10 complete working days of participant observation in two hospitals in Western Sweden[7]. All observations were carried out on the days suitable for the participants involved in the study. A number of interviews were conducted during or after the observation sessions as well. The head nurse permitted observations and the recordings of rounds. I was present at the hospital from the beginning of duty hours until the night shift and participated in all the routines in which the non-Swedish physicians were involved. Field notes were used for data recording.

3.2.5 Relations between the four types of data collection

The four types of data collection used in the study, namely interviews, questionnaires, recordings of medical consultations and observations are interrelated. I conducted the interviews first, and the aspects most often mentioned by the participants constituted the basis for the questionnaires. In addition, the interviews and observations provided opportunities to make contact with the non-Swedish physicians, Swedish physicians, other personnel and patients and to ask them to participate in recordings of consultations. In the case of the patients, short interviews conducted after they had completed the questionnaire proved to be beneficial: they provided an opportunity to get more detailed comments about communication and to avoid a potential lack of understanding/misunderstanding of the answers obtained. As already mentioned, I combined the analysis of interviews and questionnaires with the analysis of recordings of medical consultations. More information about data analysis appears in section 3.5.

3.2.6 Ethical considerations

Anonymity was emphasized in the study. The participants' names and other material facts, such as place names, hospital names, identification numbers, etc., have been altered to preserve their anonymity.

I have already mentioned the use of consent forms in describing the procedure for recording medical consultations. Physical examinations were not video-recorded. Depending on the participants' agreement, the camera was switched off or the cap was placed on the lens by a physician, a nurse or a research assistant before the physical examination. In the first case, it resulted in a jump in time, in the second in an audio recording of interaction during the examination. In some cases, the whole consultation was audio-recorded only. This was done at the participants' request (e.g., for reasons of inappropriate clothes, a close physical examination, feelings of uneasiness, etc.). If a physical examination did not take place, the whole interaction was video-recorded. The participants were also informed that they could break off their participation at any time and ask the project assistant to discard the recording.

7. More detailed information is not provided to protect anonymity.

3.3 Participants

As was stated above, five categories of participants, “non-Swedish physicians,” “Swedish physicians,” “other Swedish health care personnel,” “other non-Swedish health care personnel” and “Swedish patients,” were involved in the research project. Table 8 below presents a general overview of the participants.

Table 8: General overview of participants

Participant category	Number
Non-Swedish physicians	107
Swedish physicians	14
Other Swedish health care personnel	107
Other non-Swedish health care personnel	8
Swedish patients	157
Total: 393 participants	

The criteria for selecting the participants were as follows. Starting with the non-Swedish physicians, only those who had obtained their medical education and work experience in their homelands and had some work experience in Swedish health care were chosen. The same applies to the other non-Swedish health care personnel.

The Swedish physicians, other Swedish health care personnel and Swedish patients were all native speakers of Swedish. The health care personnel included representatives of different occupational groups, such as nurses, assistant nurses, laboratory assistants, etc. Below, brief descriptions of the participants in each category are presented.

3.3.1 Non-Swedish physicians

In total, 107 non-Swedish physicians from 25 countries and with 19 different specialties participated in the study. The majority of them (85) completed the questionnaire only, while 22 physicians were involved in the interviews and/or recordings of medical consultations. The respondents’ age ranged between 28 and 66, with work experience of up to 24 years in their respective home countries. Time spent in Sweden and work experience as a physician in Sweden varied from less than one year to 36 years. Amount of Swedish language education ranged between 0 (Swedes from Finland) and 12 years. A detailed overview of the questionnaire respondents is presented in Appendix D. A wide variety of specialties is represented (see Appendix D and Tables 9 and 11 below). In the subsequent section, brief descriptions of the non-Swedish physicians who participated in the interviews and/or recordings are presented, followed by a brief overview of the questionnaire respondents.

3.3.1.1 Non-Swedish physicians: recordings of medical consultations and interviews

Twenty-two non-Swedish physicians participated in the interviews and/or recordings of medical consultations. The participants are grouped according to their countries of origin. The Hungarian and the Iranian physicians are grouped in the Iranian and the Hungarian group respectively. The physicians from other countries are grouped in the so-called Mixed group. The non-Swedish physicians who participated in the recordings of medical consultations and interviews are presented in Table 9.

Table 9: Information on the non-Swedish physicians who participated in interviews and recordings of medical consultations

Participant code	Age	Gender	Specialty	Years as physician		Time in Sweden (years)	Number of recordings		Participated in an interview yes (+) no (–)
				in home country	in Sweden		video	audio	
Hungarian group, Country of origin: Hungary (Hu); Region: Central Europe									
HuD1	45	male	anesthesiology	20	1	1	2	0	+
HuD2	34	female		7	1	1	2	0	+
HuD3	36	male		9	1.5	1.5	4	0	+
HuD4	44	male		11	2	2	3	1	+
HuD5	48	female	radiology	22	2.5	2.5	0	0	+
Iranian group, Country of origin: Iran (Ira); Region: Middle East									
IraD6	49	female	geriatrics, rehabilitation	4	10	13	1	0	+
IraD7	40	female	general practice	5	>1	7	0	2	–
IraD8	45	male	surgery	5	13.5	14	3	0	–
IraD9	48	male	ophthalmology	3.5	16	17	6	0	+
IraD10	50	female	obstetrics, gynecology	8	15	18	3	0	+
IraD11	49	male	surgery	>1	19	23	0	0	+
Mixed group; Countries of origin: Germany (Ger), Iraq (Iraq), China (Chi), Colombia (Col), Poland (Pol), Russia/former USSR (Rus), former Yugoslavia (Yug), Norway (Nor), Finland (Fin); Regions: Western Europe, Eastern Europe, Middle East, Asia, Latin America, Northern Europe									
GerD12	56	male	orthopedics	30	1	1	2	0	+
GerD13	27	female	surgery	>1	1.5	1.5	0	0	+
IraqD14	48	male	surgery	20	1	3	0	0	+
ChiD15	40	female	general practice	>1	>1	12	0	0	+
ColD16	39	male	surgery	2	10	12	2	0	+
PolD17	42	female	radiology	17	3	3.5	0	0	+
RusD18	45	female	general practice	45	10	14	2	0	+
YugD19	35	female	anesthesiology	>4	>2	2	1	0	+
NorD20	33	male	surgery	>1	4	10	0	0	+
NorD21	66	male	general practice	>1	36	36	0	0	+
FinD22	47	female	geriatrics, rehabilitation	>1	22	28	0	0	+
Total 22 physicians, countries, 11 male and 11 female									

The majority of the participants come from two countries, Hungary and Iran. The physicians

from Germany, Iraq, China, Colombia, Poland, former USSR (Russia), former Yugoslavia, Norway, and Finland make up the so-called Mixed group.

The specialties and time spent in Sweden vary for the participants in the different groups. Concerning the Hungarian group, all but one physician (HuD5, a radiologist) were anesthesiologists and had been in Sweden for 1 to 2.5 years at the time of the recording. All the participants in this group were recruited under the Region Västra Götaland recruitment program and, since their medical licenses were automatically approved due to EU/EEA regulations, started to work directly after coming to Sweden. Swedish language training was received in a three-month Swedish language course in Hungary.

The representatives of the Iranian group and selected physicians from the Mixed group (the physician from Iraq [IraqD14], and the Chinese [ChiD15], Colombian [ColD16], Russian [RusD18], and Yugoslavian [YuD19] physicians), started working in the Swedish health care system 3 to 6 years after coming to Sweden, after they had completed their medical education and passed the compulsory language examination for physicians from outside EU/EEA in order to get their medical licenses approved (see Chapter 1). The German male (GerD12) and the Polish female (PolD17) physicians were recruited within similar recruitment programs for German and Polish physicians as for the Hungarian physicians. The German female participant (GerD13) came to Sweden via her own contacts. The physicians from Norway (NorD20 and NorD21) had been working in Sweden for a considerable time, as had the Finnish physician (FinD22). The specialties of the physicians from the Iranian group comprised geriatrics, rehabilitation, surgery, ophthalmology, gynecology and primary care. The specialties of the physicians from the Mixed group were surgery, primary care, radiology, orthopedics and general practice.

In total, 13 physicians participated in the recordings of medical consultations and those recordings were included in the study. Nine physicians (HuD5, IraD11, GerD13, ChiD15, IraqD14, PolD17, NorD20, NorD21 and FinD22) were not recorded during medical consultations or the recordings were not included in the study. The reasons are limited patient contact (HuD5 and PolD18) and refusal to participate in recordings (GerD13 and IraqD14 were observed in the course of patient contact only).

All physicians but two (IraD7 and IraD8) participated in the interviews.

3.3.1.2 Non-Swedish physicians: questionnaires

In total, 85 non-Swedish physicians answered the questionnaires. They are grouped according to region and country of origin. Table 10 presents a general overview of the participants.

Table 10: General overview of questionnaire respondents: non-Swedish physicians

Region	Countries	Number	Gender	
			male	female
Western Europe	Germany	29	18	11
	Belgium	1	0	1
Central Europe	Hungary	12	8	4
Baltic states and Eastern Europe	Czech Republic, Latvia, Lithuania, Romania, Poland	10	5	5
Middle East	Iran, Iraq, Lebanon, Syria	10	9	1
Mediterranean	Greece, Italy, Spain	8	7	1
Northern Europe	Finland, Iceland	7	4	3
Southern Europe	former Yugoslavia (Bosnia, Macedonia, Serbia)	5	1	4
Latin America	Argentina, Colombia	2	2	0
Asia	China	1	1	0
Total: 85 participants; 23 countries, 55 male and 30 female				

As we can see, most respondents were from Germany, followed by Hungary, the Baltic states and the Middle East. For more information, see Appendix D.

3.3.2 Swedish physicians

Fourteen Swedish physicians participated in the project. Nine of them took part in the interviews and/or recordings of medical consultations and six responded to the questionnaire.

3.3.2.1 Swedish physicians: recordings of medical consultations and interviews

Detailed information about each of the Swedish physicians who participated in interviews and/or recordings is presented in Table 11 below. There is no information about the exact age of the Swedish physicians SweD1, SweD2 and SweD3. According to the researchers from the "Communication in Health Care with Regard to Drug Prescription" project, their age ranges between 30 and 45 years.

Table 11: Information on the Swedish physicians who participated in interviews and recordings of medical consultations

Participant code	Specialty	Age	Gender	Number of recordings		Participated in an interview yes (+) no (–)
				video	audio	
SweD1	general practice	30-45	male	0	3	–
SweD2		30-45	male	0	9	–
SweD3		30-45	male	0	2	–
SweD4	surgery	40	male	2	0	–
SweD5		27	male	4	0	+
SweD6	general practice	52	female	4	0	–
SweD7	surgery	33	female	5	0	–
SweD8	blood diseases	58	male	0	0	+
SweD9	general practice	47	male	0	0	+
Total: 9 participants, 7 male and 2 female						

The majority of the participants (7 out of 9) agreed to have consultations recorded and three – SweD5, SweD8 and SweD9 – were interviewed.

3.3.2.2 Swedish physicians: questionnaires

Six Swedish physicians, four male and two female, responded to the questionnaire. For more detailed information, see Appendix D.

3.3.3 Other Swedish health care personnel

3.3.3.1 Other Swedish health care personnel: interviews

Other Swedish health care personnel including nurses and assistant nurses were interviewed; their demographic information appears in Table 12:

Table 12: Overview of other Swedish health care personnel who participated in interviews

Participant code	Occupation category	Specialty	Age	Gender
SweN1	nurse	surgery	39	female
SweN2			30	female
SweN3			28	male
SweN4			35	female
SweAN5	assistant nurse		57	female

3.3.3.2 Other Swedish health care personnel: questionnaires

In total, 102 respondents from different work categories completed the questionnaire; an overview is presented in Table 13.

Table 13: General overview of questionnaire respondents: other Swedish health care personnel

Occupation category	Number	Gender	
		male	female
Nurses	54	7	47
Assistant nurses	26	0	26
Physiotherapists	12	1	11
Care assistants and laboratory assistants	10	3	7
Total: 102 participants, 11 male and 91 female			

The age of the respondents ranged between 20 and 70. All but one female physiotherapist were educated in Sweden. The number of years working in Swedish health care varied between one year and 40 years. For more information, see Appendix D.

3.3.4 Other non-Swedish health care personnel

Information on the other non-Swedish health care personnel who participated in the interviews is presented in Table 14.

Table 14: Information on interview participants: non-Swedish health care personnel

Participant code	Occupation category	Specialty	Age	Country of origin	Gender
N-SweN1	nurse	surgery	41	Norway	female
N-SweN2			40	Ethiopia	
N-SweN3			55	Spain	
N-SweN4			50	Ireland	
N-SweN5			35	Philippines	
N-SweN6			41	Hungary	
N-SweN7			40	Iran	
N-SweAN8	assistant nurse		37	Israel	
Total: 8 participants, 7 nurses, 1 assistant nurse; all female					

3.3.5 Swedish patients

A total of 152 Swedish patients participated in the study. The information on these patients is provided in Table 15.

Table 15: Information on the Swedish patients who participated in the interview, recording of medical consultation and/or questionnaire

Participant code	Number	Age	Gender		Participated in			
			male	female	interview	recording of medical consultation		questionnaire
						video	audio	
P1–P62	63	20–90	32	31	0	46	17	0
P63–P72	10	20–80	4	6	10	0		10
P73–P77	5	25–40	5	0	5	0		0
P78–P152	74	20–90	40	34	0	0		74
Total: 152 participants; 81 male and 71 female								

The majority of the patients were involved in the questionnaire and recordings. Sixty-three patients participated in the recordings of medical consultations. Ten patients out of the 84 who responded to the questionnaire also participated in interviews. Five patients participated in the interviews only.

For more information on the patients who responded to the questionnaire, see Appendix D.

3.3.6 Relations between data from the four data collection methods

I collected my data in a limited number of health care institutions. In the majority of cases, several participants, including non-Swedish physicians, Swedish physicians and other personnel were employed at the same workplace, which made it possible, for example, to get both the non-Swedish physicians' and the Swedish personnel's points of view on communication. This proved to be positive for data analysis. Some participants also participated in several data collection methods. This applies primarily to the non-Swedish physicians, some of whom were involved in interviews, questionnaires and recordings of consultations. This enabled me to obtain different kinds of data and consequently gain better insight into the participant's behavior.

3.4 Some additional remarks on data collection

Data for the project were collected in health care institutions, care centers and hospitals[8] in Western Sweden. The choice of the institutions was influenced by availability of the participants among non-Swedish physicians who agreed to participate in the project. The wide variety of wards and specialties represented can be seen both as a weakness and a strength of the research. On one hand, it would be better to have a more homogeneous group of wards, due to the apparent differences in routines, consultation structure and contents, etc. The relatively calm atmosphere of, for example, a rehabilitation ward, where a physician can spend a lot of for talking to a patient, cannot be compared to a care center, where the average time a physician can spend with a patient often hardly exceeds 20 minutes. On the other hand, unrelated to these factors, the data obtained represent a variety of communicative situations and enable us to analyze non-Swedish physicians' communication in these situations.

The data collection process was not unproblematic, especially in the case of the recordings of medical consultations. First, the nature of the interaction can be rather sensitive, for both physician and patient. Second, it might be even more sensitive as the physician-foreigner might feel that the recording is a kind of "test" of his/her Swedish language competence, especially at the beginning of his/her work career in Sweden, after a long period of language training, completion of medical education, etc. Being a newcomer results in a feeling of being singled out and, consequently, often (though not necessarily) in more or less conscious

8. The actual health care centers and hospitals are not identified here in order to protect the participants' anonymity.

attempts to melt into the group. Participation in the recording of consultations as a foreign physician might cause anxiety and fear, and give rise to feelings of being further "singled out." Furthermore, in spite of the promised and emphasized anonymity, a non-Swedish physician might still be suspicious about it. All these factors added to the difficulty of finding non-Swedish physicians to participate in the study. Hence, again, I would like to express my deep gratitude to all the participants in the study, especially the non-Swedish physicians, for their valuable contributions.

3.5 Data analysis

As mentioned above (section 3.1), the data presented in this thesis were analyzed according to Activity Based Communication Analysis (ACA). I mentioned that I have combined the analysis of interviews, questionnaires, observations and recordings of medical consultations. In this section, I will provide more information on how each type of data was analyzed and how the analyses were combined.

3.5.1 Analysis of the recordings of medical consultations

The recordings of medical consultations were transcribed and checked. The **transcriptions** were done directly from the recordings by three project assistants (native speakers of Swedish) according to a specific transcription standard. In our case, this standard was GTS and MSO (Göteborg Transcription Standard + Modified Standard Orthography; Nivre et al., 2004), developed at the Department of Linguistics, University of Gothenburg. This standard is closer to spoken language than standard Swedish orthography but at the same time not as detailed as a phonetic or phonemic transcription would be (Allwood et al., 2000); consequently, it allows one to include in transcriptions such features of spoken language as overlaps, pauses, contrastive stress, comments on non-verbal behavior and other events. Standard orthography (SO) is used unless there are several spoken language pronunciation variants of a word. When there are variants, these are kept apart graphically (Allwood et al., 2000). This factor is relevant for this study, as, due to the non-Swedish physicians using Swedish as a foreign language, the number of such forms is relatively high.

It should be mentioned here that in GTS there are three transcription formats with different levels of specification, namely SSM (SkriftSpråksMotsvarighet = written language correspondent), DT (Disambiguerat Tal = disambiguated speech transcription) and IDT (Icke Disambiguerat Tal = non-disambiguated speech transcription). Below, I provide an example to illustrate how the same utterance can be presented in the three formats, with some explanations from Allwood et al. (2002):

Table 16: Differences between SSM, IDT and DT

SSM	IDT	DT
åttiofyra år fyllde jag alldeles nyss	åttifyra år fyllde ja alldeles nyss	åtti{o}fyra år fyllde ja{g} alldeles nyss
the way it would be represented in standard written language	written "as it sounds" if conventionalized variants exist in speech, otherwise with standard orthography, e.g., in speech *ja* can mean 'I' or 'yes', while in writing *ja* ('yes') is differentiated from *jag* ('I').	DT represents IDT forms with additions allowing correspondence with standard written language words by curly brackets or numerical indices, e.g., ja => ja{g} ('I'), och -> å0 ('and')

DT is the basic format for transcription in GTS; it can be used for transfer to IDT and SSM, but not vice versa, since DT contains more information than either IDT or SSM.

In the thesis, I have used IDT for the presentation of transcriptions, as it is more reader-friendly and closer to what the participants actually hear and use. However, for quantitative data analysis, such as retrieving data for corpus analysis, the DT format has been used and later transferred into IDT.

The transcriptions in the thesis are presented in the Swedish original and an English translation. However, as comments on non-verbal behavior are provided in English in the original Swedish transcriptions, they are represented for both Swedish and English versions. A sample transcription is presented in Table 17:

Table 17: Sample transcription (IDT format)

	Transcription	Translation into English
$D:	<1 ja jenny hur gammal >1 är <2 dy >2	*<1 well jenny how old >1 are <2 you >2*
@ <1 gaze: looking down in the medical file >1 @ <2 SO: du/you >2		
$P:	ja åttifyra år // [fyllde ja] alldeles nyss	*well eighty-four years // [I turned] recently*
$D:	[åttify:ra år]	*[eighty-fo:ur years]*
$A:	ÅTTIOFEM fyllde du jenny	*you turned EIGHTY-FIVE jenny*
$P:	< ja åtti fem ja >	*< yeah eighty-five yeah >*
@ < head movement: towards the side >		
$A:	<1 ja // >1 hade du inte <2 (kalas) eller >2 <3 / >3	*<1 yeah // >1 didn't you have a < (party) >2 <3 / >3*
@ <1 laughter: D >1, <1 facial gesture: P smiles >1 @ <2 gaze: P looks at A >2 @ <3 laughter: D >3		

The symbols used in the example are explained in Table 18. For a more comprehensive overview of the GTS and MSO standard, see Allwood et al. (2000) and Allwood et al. (2003).

Table 18: Transcription conventions

Symbol	Explanation
$P, $D,	participant (patient, doctor)
[ ]	overlap brackets; numbers used to indicate the overlapped parts
( )	transcriber's uncertainty of what is being said, e.g., (pritsche)
/, //, ///	short, intermediate and long pause, respectively
+	incomplete word, pause within word
CAPITALS	stress
:	lengthening
< >, @ < >	comments about non-verbal behavior, comment on standard orthography, other actions
< SO: du >	SO stands for standard orthography. The dialectal forms of Swedish and incorrect forms used by the non-Swedish physicians are commented on in the line below

Transcriptions were **checked**, first by a checker (a different person than the transcriber) who went through and checked every transcription against the recorded data. Second, there was also an automatic computer-supported control. *Transkoll*, developed by Leif Grönqvist at the Department of Linguistics, University of Gothenburg, was used to ensure that all transcription conventions were followed consistently. Both transcribers and controllers were native speakers of Swedish.

The next step in analyzing the recordings of consultations was the **compilation of corpora**. The transcriptions of the recordings were compiled into two corpora, the Intercultural Medical Consultation (ICCMedConsult) and the Swedish Medical Consultation (SweMedConsult) corpora, which comprise the transcriptions of recordings of medical consultations from the ICCMedconsult Study and the SweMedConsult Study, respectively.

The ICCMedconsult corpus includes transcriptions of the above-mentioned 34 recordings of medical consultations between non-Swedish physicians and their Swedish patients. The recordings are divided into three groups according to the non-Swedish physicians' group: Hungarian, Iranian, and Mixed.

The speakers are grouped into three main categories, namely "Non-Swedish physicians" (including Hungarian, Iranian and Mixed physician subcategories), "Patients of non-Swedish physicians" (including patients of Hungarian, Iranian and Mixed physician subcategories) and "Other." The participants in the "Other" category include participants other than the physician and the patient who were present during consultations, such as nurses, patients' friends, relatives, research assistant(s)[9], etc. As the focus of this study is physician-patient communication, the analysis for the category "Other" is not presented.

The SweMedConsult corpus comprises transcriptions of 29 recordings of medical consultations. As was mentioned in 3.2.3, 15 recordings were made within the "Communication and Interaction in Intercultural Health Care" project. All of them were transcribed within the framework of this project. Fourteen recordings were made during the previous research project entitled "Communication in Health Care with Regard to Prescription," within which they were transcribed and afterwards included in the Göteborg Spoken Language Corpus (GSLC). The Göteborg Spoken Language Corpus (Allwood et al., 2003) is a corpus of spoken language developed at the Department of Linguistics, University of Gothenburg. It now consists of approximately 375 recordings (totaling 1.4 million words) of about 25 different social activity types, including physician-patient consultations, auctions, court proceedings, meetings, etc.

As in the ICCMedconsult corpus, the participants are grouped into three categories: "Swedish physicians," "Patients of Swedish physicians" and "Other." The category "Other" is similar to that in ICCMedconsult and will not be analyzed. Table 19 presents an overview of both corpora.

9. As mentioned in 3.2.3 and 3.2.6, research assistants were not present during consultations. However, in some cases, the researcher's voice is recorded while thanking the participants for their participation, informing them that the camera is turned on, etc.

Table 19: Description of corpora

Participant categories	Number of words	Participant categories	Number of words
ICCMedConsult		**SweMedConsult**	
Consultation types: *anesthesiology, gynecology, eye, general practice, rehabilitation, intensive care, orthopedics, surgery*		*surgery and general practice*	
Non-Swedish physicians	31 037	Swedish physicians	28 727
Hungarian physicians	*9 352*		
Iranian physicians	*12 112*		
Mixed physicians	*9 573*		
Patients of non-Swedish physicians	26 958	Patients of Swedish physicians	22 120
Patients of Hungarian physicians	*8 455*		
Patients of Iranian physicians	*10 656*		
Patients of Mixed physicians	*7 847*		
Other	2 631	Other	2 132
Total incl. other	**60 626**	**Total incl. other**	**52 979**
Total excl. other	**57 995**	**Total excl. other**	**50 847**

As Table 19 shows, the ICCMedConsult corpus is bigger than the SweMedConsult corpus and contains a greater variety of consultation types, which is taken into consideration in the data analysis. As mentioned above, the contributions of the participants in the category "Other" are not analyzed here. Henceforth, when referring to the corpora as ICCMedConsult and SweMedConsult, I refer only to the contributions of the physicians and patients.

A reasonable question arises here: What happens when interaction depends on "other" participants? First of all, as one can see, the number of words produced by the participants in this category is rather low (about 4% of each corpus). Second, in the recordings, the majority of contributions by "other" participants are limited to the recording procedure, minor comments from the patients' companions and comments by nurses. None of the selected recordings includes long passages of talk between the "other" participant and the physician/ patient. Therefore, their influence on the course of the interaction is minor.

According to ACA, data analysis implies a combination of quantitative and qualitative methods.

The **quantitative analysis of corpora** comprises statistical analyses of transcriptions and analysis of word use in context. Statistical analysis of transcriptions is done by a number of computer programs for processing transcriptions, more specifically *Göralt* ('Do-all') (Allwood et al., 2003) and *Tal-till-tal* ('speech to numbers') (Hartzell and Mäkk, 2003). Among other things, I have looked at the use of vocabulary, feedback and pauses, as well as the most common parts of speech. In addition, a concordance program, *Lgconc*, developed by Leif Grönqvist at the Department of Linguistics, University of Gothenburg, was used to obtain text samples of specific words in order to gain a better understanding of their use in interaction. A screen shot from *Lgconc* is shown in Figure 1.

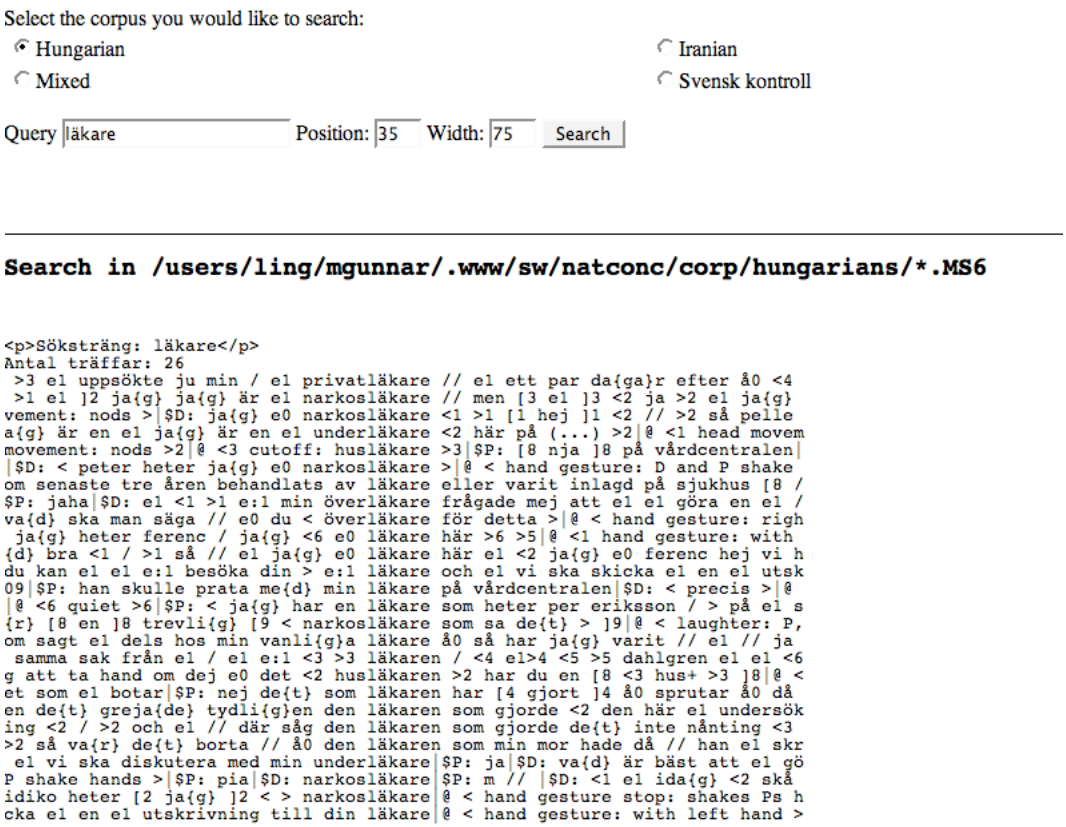

Figure 1: Screen shot from *Lgconc*

Statistical corpus analysis is a relatively uncommon method in health care communication research. An example of the corpus approach to the analysis of language used in interaction is presented by an article by Skelton and Hobbs (1999b) in which the concordance tool is used to examine the use of jargon by physicians, as well as to investigate the aspects of power relationships in interaction, stressing the necessity to combine quantitative methods with a qualitative assessment. From this perspective, this study adds something new to health care communication research in general, and to intercultural physician-patient communication research in particular.

Apart from a more general quantitative analysis of recordings, as I mentioned in Chapter 2, section 2.3, I am interested in the analysis and comparison of information eliciting, information providing and giving feedback by the participants in the intercultural and Swedish medical consultations. The **qualitative analysis of corpora** done for the thesis includes analysis of the following aspects of linguistic interaction:

- Information seeking: Analysis and comparison of question types and usage in intercultural and Swedish medical consultations by the non-Swedish and Swedish physicians and their respective patients.
- Information providing: I have focused on the analysis and comparison of usage of the impersonal pronoun *man* (‘one’) by the Swedish and the non-Swedish physicians in the instances when the physicians provide information to their patients.

- Giving feedback: Analysis and comparison of usage of repetitions and reformulations in intercultural and Swedish medical consultations by the non-Swedish and Swedish physicians and their patients.
- In addition, the instances when communication problems arise, such as lack of understanding/misunderstanding, have been identified and analyzed, as have sequences in which cultural differences are salient.

I analyze and compare contributions in light of activity purpose and roles as well as gender and physicians' countries of origin.

The analyzed data from ICCMedConsult and SweMedConsult were compared; concerning statistical results, the differences observed were tested for significance using the t-test and $\chi 2$ test. The analysis was done with regard to gender as well as language and cultural differences. More information on this topic appears in Chapters 5 and 6.

3.5.2 Analysis of interviews, questionnaires and observations

The interviews and questionnaires were analyzed with regard to the themes they deal with. Simple descriptive statistics were used to analyze the questionnaires in combination with the analysis of selected transcribed sequences from the interviews. A number of questions with the corresponding comments were selected for study. The non-Swedish physicians' answers have been analyzed for those physicians as a group as well as taking into account two criteria: gender and country of origin. The Swedish patients' answers were analyzed with regard to gender, age, and education. The questions within each part were grouped into three themes. In Table 20 below, an overview of the themes is presented.

Table 20: Themes related to the analysis of interviews and questionnaires concerning physician-patient communication

Views on communication
Non-Swedish physicians' questionnaire: Q 14a, 29 Swedish patients' questionnaire Q 13a, 14a, 19, 21, 23 Comments, interviews
Reasons for lack of satisfaction/dissatisfaction with communication. Language problems and cultural differences experienced by the participants
Non-Swedish physicians' questionnaire: Q 14b, 23, 24, 25, 26, 28, 32 Swedish patients' questionnaire Q 13b, 15, 16, 17, 18, 25, 30 Swedish personnel's questionnaire Q.11 Comments, interviews
Positive aspects of meeting non-Swedish physicians
Swedish patients' questionnaire: Q.20 Comments, interviews

In addition, Q.27 from the Swedish patients' questionnaire was used in the analysis of information seeking (section 5.1). The respondents' answers were counted, categorized and summed up. Note that in some cases the respondents had chosen more than one alternative. As a result, sometimes the total percentage is over 100. All comments were taken into account when analyzing the answers.

In the majority of cases, the structure of the interviews and the questionnaires allows comparison of the answers of the non-Swedish physicians, the Swedish patients and the Swedish and non-Swedish personnel. A number of questions with similar contents but

slightly modified to fit the different categories of respondents were constructed. For example, Q.25 in the questionnaire for the non-Swedish physicians and Q.18 in the questionnaire for the Swedish patients address the occurrence of misunderstandings in communication from the physicians' and patients' points of view.

The design of the questionnaire addressed to the Swedish patients also allows the analysis of the patients' answers with regard to differences in satisfaction with communication in same-sex and cross-sex medical consultations. As each patient reported on one encounter, a total of 84 encounters were described by all the patients. Sixty-seven Swedish patients experienced communication with male non-Swedish physicians and 17 with female non-Swedish physicians.

Concerning observations, the field notes proved to be beneficial for a better understanding of the issues mentioned in the interviews and questionnaires.

3.5.3 Relations between the analysis of data from the recordings of medical consultations, interviews, questionnaires and observations

The diagram below provides an overview of the data analysis done for the study:

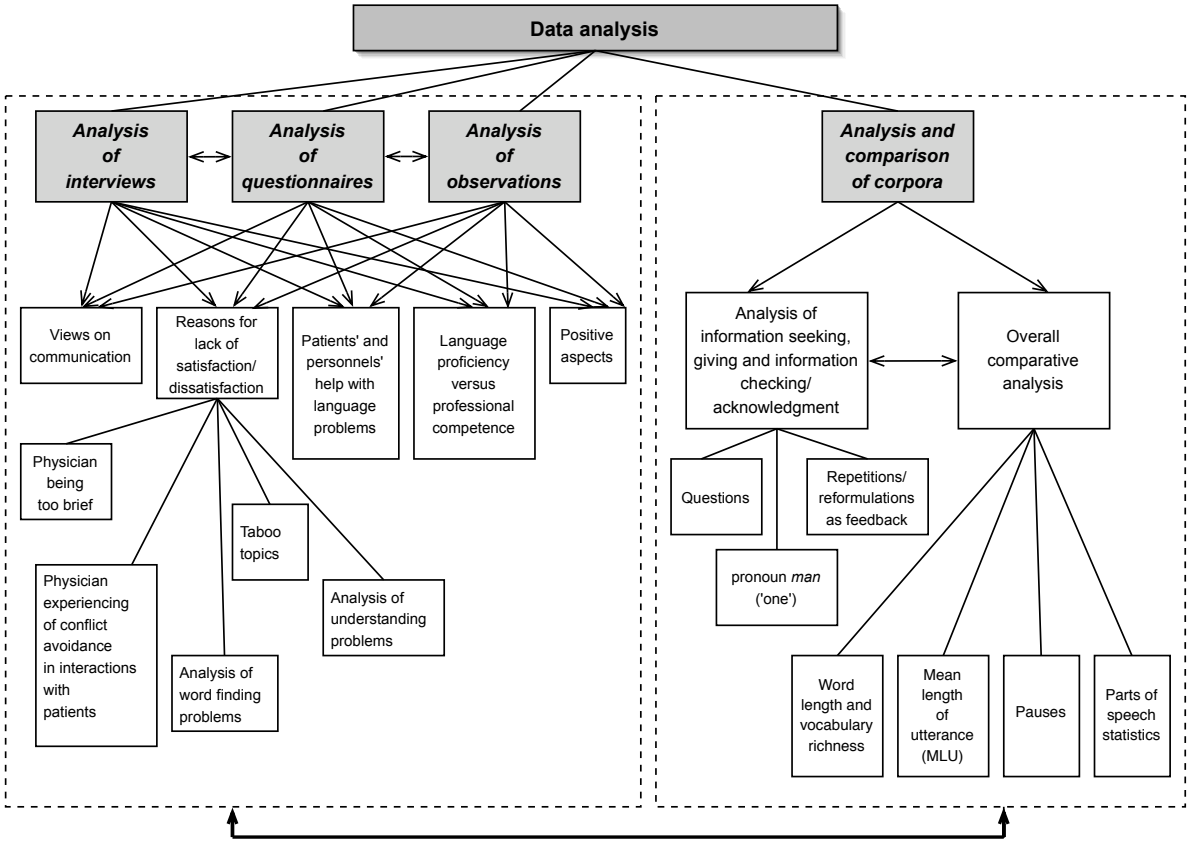

Figure 2: Data analysis: an overview

As I mentioned earlier, I combined different data collection and data analysis methods in order to get as complete a picture as possible of communication in medical consultations. As Figure 2 above shows, in the majority of cases, material from all four sources (i.e., observations, interviews, questionnaires, and recordings of medical consultations) was used to analyze the phenomenon. Concerning the participants' views on communication, language versus professional competence, and the positive aspects of intercultural communication between the non-Swedish physicians and their Swedish patients, data primarily from the interviews and questionnaires were used, though I tried to combine them with examples and analysis of actual interactions between the non-Swedish physicians and their communication partners, when possible. For example, from the transcriptions, the excerpts in which communication problems occurred, cultural differences were salient, etc., were selected and presented together with comments from the interviews and/or questionnaires that concern these issues. This was done, for example, in the study of problems with understanding.

3.6 Some comments concerning translation

This thesis contains many examples from the transcriptions of the recorded interactions, interviews and comments from the questionnaires in Swedish; moreover, the majority of them include the speech of the non-native speakers. In translating the examples into English, I have done my best to make it as clear as possible for the reader what phenomenon each one illustrates. In some cases, this has resulted in some loss of literal meaning.

3.7 Summary of Chapter 3

In this chapter, I provided information about the data used in the thesis and collection and analysis methods, including ethical issues and problems with the data collection process. In addition, the participants of the study and the criteria for their selection were presented. Chapters 4 to 6 present the results of the data analysis.

Chapter 4: Activity analysis. Integrated analysis of interviews, questionnaires and recordings of medical consultations

This and the next two chapters of the thesis provide a description and analysis of intercultural communication between non-Swedish physicians and their patients, considering both problems and positive aspects. In this chapter, I present an activity coding for medical consultation, followed by an integrated analysis of interviews, questionnaires and recordings of medical consultations. In order to make it easier for the reader to follow, I provide a brief overview of the chapter contents in Table 21.

Table 21: Layout of Chapter 4

(Sub) section	Title	Empirical data used
4.1	**Medical consultation as a social activity: a brief activity analysis**	questionnaires interviews recordings of medical consultations observations
4.1.1	*Medical consultation as a social activity*	
4.1.2	*Types of consultations represented*	
4.1.3	*Role of activity expectations on communication and effects of physicians' language and cultural background*	
4.2	**Views on communication (Non-Swedish physicians and Swedish patients)**	questionnaires interviews observations
4.2.1	*Participants' views of physician's tasks in medical consultation*	
4.2.2	*Participants' satisfaction with communication*	
4.2.3	*Comparison of communication - Swedish and non-Swedish physicians and Swedish and non-Swedish patients*	
4.3	**Reasons for lack of satisfaction/dissatisfaction with communication: language problems and cultural differences experienced by the participants**	questionnaires interviews recordings of medical consultations observations
4.3.1	*Being too brief: a consequence of lack of language competence, cultural differences or both?*	
4.3.2	*"You never know what the patient thinks of you as a non-Swedish physician": the influence of Swedish conflict avoidance on the physician-patient relationship*	
4.3.3	*Problems with understanding in communication between non-Swedish physicians and Swedish patients*	
4.3.3.1	*Analysis of problems with understanding in medical consultations: data from the questionnaires*	
4.3.3.2	*Analysis of problems with understanding in medical consultations: data from the interviews and recordings of medical consultations*	
4.3.4	*Word-finding problems in communication between non-Swedish physicians and Swedish patients*	
4.3.5	*Taboo topics in interactions between non-Swedish physicians and Swedish patients*	
4.4	**Swedish patients as informal teachers: help with language problems during consultations**	questionnaires interviews recordings of medical consultations observations
4.5	**The relationship between language proficiency and professional competence**	questionnaires interviews observations

4.6	**Reported positive aspects of intercultural medical consultations**	questionnaires interviews recordings of medical consultations observations
4.7	**Summary of Chapter 4.**	

Power relationships are one of the key issues examined here. As can be judged from the data overview in the previous chapter, the participants represent a wide variety of cultures, so it is possible to make some observations about their cultures and communication. Since the number of representatives of each culture is relatively low, the conclusions drawn are often tentative. The analysis was also done with regard to gender (i.e., male and female physicians' and patients' views and communication patterns were compared). Furthermore, in some cases, the patients' education level and age are discussed in relation to communication issues.

4.1 Medical consultation as a social activity: a brief activity analysis

An understanding of the activity structure of medical consultations is essential for an understanding of the communicative behavior of the participants involved in a consultation. Below, I provide a general description of the medical consultation as a social activity, followed by comments on the differences characterizing the various consultation types represented in the thesis.

Consultation is a type of a counseling activity. A person comes to see a physician in order to acquire information about the state of his/her health or advice about a necessary treatment. It is important to achieve a shared understanding of the problems in the consultation; this understanding encompasses not only the physician's interpretation of the patient's complaints, but also the patient's comprehension of the medical explanation provided by the physician. This motivates each participant to be attentive to the other. The physician wants to get as much relevant information from the patient as possible, and attempts to understand the patient's conception of the disease. The same is true of the patient, who tries to explain his/her problem to the physician in the best way he/she can in order to get the necessary help, and attempts to understand the physician.

Below, I provide an activity coding and description of medical consultation, following ACA and focusing on the following activity parameters (Allwood, 2007a, p. 7):

- **Purpose, goals, procedure(s):** in Allwood's terms, the "teleological aspects of an activity," that is, why the activity exists, and what the participants involved in the activity attempt to achieve.
- **Roles: rights, obligations and competence:** "the expectations (and sometimes formal requirements) which exist concerning the rights, obligations and competence needs that are associated with a particular role in an activity" (p. 7).
- **Artifacts:** instruments, tools, and media which are needed for the participants to pursue an activity (p. 7).
- **Environment (social, physical):** "environment" comprises "social environment" (culture, social institution and organization) and "physical environment" (lighting, sound,

temperature, furniture, etc.).

My coding is partially based on the activity coding provided in Allwood (2001b).

4.1.1 Medical consultation as a social activity

Table 22: Medical consultation: purpose, activity structure, goals and procedures

	Activity structure	Goals	Procedures
PURPOSE to help solve the patient's health problems	• Greeting, introduction • Identification of the reason for coming (if unknown) • History taking/ providing • Examination (if necessary) • Diagnosis • Prescription • Conclusion and leave-taking	**If first visit:** • get and provide relevant and necessary information: patient (and accompanying person)/physician (or other medical personnel) • check if the received information is correct • perform a physical examination (if necessary) • make a diagnosis (for the physician) • determine treatment (for the physician primarily; higher or lower degree of involvement from the patient) **If not:** • check the patient's current condition • get and provide relevant and necessary information: patient (and accompanying person)/physician (or other medical personnel) • check if the received information is correct • decide whether the patient should continue with the current treatment or determine a new treatment (for the physician primarily; higher or lower degree of involvement from the patient)	The physician (and the nurse if present) and the patient (and accompanying person) greet each other. **If first visit:** • The reason for the patient's visit is determined • The physician makes a diagnosis by asking questions and/or making physical examination • The treatment is determined **If not:** • The patient's current condition is clarified • Then a decision concerning patient's proceeding with the current treatment and/or starting a new one is made • The physician gives instructions to the patient (and accompanying person) • The time of the next visit is booked if necessary

The **purpose** of a medical consultation is to help the patient to solve health problems. The **activity structure** of the activity comprises greeting/introduction, identification of the reason for coming (if unknown, though it is possible for the physician get information about it before the consultation), collecting relevant information (history taking by the physician/ information providing by the patient as well as physician providing information to the patient on request or spontaneously), physical examination (if necessary), making a diagnosis (if necessary – in the case of a follow-up visit the diagnosis is often known), prescription, conclusion and leave-taking. It is worth pointing out here that the above-mentioned phases do not necessarily occur in the order presented; moreover, they can overlap and recur during the consultation.

The **goals** differ depending on whether it is the first visit or a follow-up visit. If it is not the first visit, the patient's current state of health and the changes in his/her condition since the last visit are discussed. In both cases, the patient and/or an accompanying person (if any) provides the information the physician asks for as well as information the patient (and/or an accompanying person, if any) considers important for the physician to know so he/she can identify the nature of the problem and make a diagnosis. The health care provider, in his/her

turn, provides the information concerning the nature of the problem, possible causes, etc., from a medical professional perspective on request by the patient (accompanying person) or spontaneously. If necessary, a physical examination is initiated. Then, the condition is considered and the diagnosis is made by the physician (with various degrees of patient participation, depending on a number of factors (see Chapter 2), usually followed by the determination of a suitable treatment. If it is not the first visit, the participants might discuss the effects of the previous/current treatment to determine whether the patient should continue with it or not and to change it/prescribe a new one if necessary. If the participants have no questions for each other, the consultation is terminated, usually by the physician, and a time for the next meeting is assigned if necessary. The activity structure and goals are also reflected in typical **procedures** occurring in the activity.

Let us turn now to the participants involved in medical consultation, and more specifically their roles, competences, rights and obligations.

The **physician** and **nurse/other personnel** (if present) have certain **competences** (medical degree/nursing degree/other medical education as well as varied working experience (e.g., newly accredited physician or physician with long work experience).

It is sometimes complicated to draw a line between **rights** and **obligations**. For example, in medical consultation, the physician or nurse has the right to ask questions about the patient's condition. At the same time, this can be seen as an obligation: the physician has to ask questions in order to get the information necessary to assess the patient's condition and make a diagnosis. The patient has the right to get help and information from the health care providers. At the same time, the patient (and an accompanying person if there is one) has an obligation (which can also be seen as a right) to provide information about his/her condition and symptoms, drawing on experience of the disease, background history (e.g., family history, previous treatment, etc.). Such aspects as ethics, professional secrecy and doing one's best to solve the patient's problem(s) may be seen as obligations rather than rights from the physician's point of view.

The physician also has the right (or obligation) to diagnose and to assign treatment. Nurses/ other personnel should assist the physician, often in the process of physical examination. All of them are obliged to help the patient in the best possible way, keep professional secrecy and follow certain ethical norms.

A summary of the roles, competences, rights/obligations and obligations of the participants in medical consultation is presented in Table 23.

Table 23: Medical consultation: roles, competences, rights and obligations

		Competences	Rights/obligations	Obligations
ROLES	Physician	• medical degree • professional experience (varies)	• ask questions about patient's condition (r/o)[10] • make examination (r/o) • diagnose (r/o) • write prescriptions (r/o)	• do his/her best to solve the patient's problem(s) • ethics • professional secrecy
	Nurse/other personnel	• nursing education • experience (varies)	• ask questions about patient's condition (r/o) • make examination/assist physician in making physical examination (r/o)	• assist the physician during consultation to do his/her best to solve the patient's problem(s) • ethics • professional secrecy
	Patient	• knowledge and experience of the disease	• ask questions about condition (r/o)[11] • get information needed (r)[12] • get medical help if needed (r) • get prescriptions if needed (r)	• sincerity in providing information about condition and symptoms
	person accompanying the patient	• knowledge about and experience of the patient's disease (optional)	• ask questions about patient's condition (r/o) • get information needed (r)	• sincerity in providing information about patient's condition and symptoms

Medical consultation occurs in a specific **environment**, involving certain artifacts, instruments, and media, an overview of which is presented in Table 24.

Table 24: Medical consultation: artifacts, instruments, media, environment

	Instruments	Media
ARTIFACTS	• furniture • medical instruments • physician's uniform (optional) • patient's file, other documents • writing utensils	• direct speech
	Sociocultural	**Physical**
ENVIRONMENT	• participants' degree of acquaintance with each other • social and cultural backgrounds of the participants	• different kinds of medical institutions • patient's home, seniors' residence, etc. • consultation premises

The **instruments** used in this activity are furniture, medical instruments, patient's file (and other documents, for example, prescriptions), writing utensils, and the physician's uniform (optional). The participants usually use direct speech as a **medium** for communication. Concerning the **sociocultural environment**, it should be pointed out that the participants involved might be more or less acquainted with each other. Furthermore, as I have already mentioned above, their social and cultural backgrounds are important factors influencing interaction (e.g., education, age, gender, cultural background, etc.). As for the **physical environment**, consultation often occurs in different kinds of medical institutions, such as health care centers, hospitals, etc. It might also occur in the patient's home, a seniors'

10. r/o=right/obligation (when the difference is not clear-cut).

11. It is problematic to define the patient's (and the accompanying person's) asking questions about his/her condition as a right or an obligation.

12. (r)=right.

residence, etc.

4.1.2 Types of consultations represented

Two main types of consultations are examined in this thesis: general practice consultation with general practitioners and consultations with specialists, such as surgery, anesthesiology, rehabilitation, gynecological consultations and consultations with an ophthalmologist, etc. All of them have typical features and differ from each other to some extent in terms of the participants involved, topics of discussion, procedures, physical environment, etc. For example, in surgery consultations in Sweden, it is customary to have a nurse present during the interaction. Anesthesiology consultations are used before surgery, when the physician's task is to collect information about the patient's state of health in order to decide on what anesthetic to use. The physician is even obliged to inform the patient about the anesthetic technique and possible alternatives, provide pre-operative instructions, describe anesthetic procedure and the post-operative procedure and the possibility of segmented care (Kindler et al., 2005). In rehabilitation consultations, the patient's condition is discussed and a decision about a suitable rehabilitation treatment is considered. In addition, a rehabilitation consultation is often followed by a "rehabilitation team," in which apart from the physician and patient, other personnel such as a welfare officer, a psychologist, a nurse, etc., discuss the patient's state and treatment. In gynecology consultations, only female patients are involved, obviously.

4.1.3 Role of activity expectations on communication and effects of physicians' language and cultural background

What are the consequences for communication in medical consultation of the fact that the physician is a foreigner and a non-native speaker who is talking to a patient who is a native speaker? As mentioned above, the patient expects the physician to collect relevant information, check his/her current condition (if it is not the first visit), provide information the patient needs and check if the information the patient provided is correct, make a diagnosis and determine treatment. The fact that the physician has a different linguistic and cultural background might influence communication because of language problems and cultural differences, which might be exhibited in how the physician fulfills his/her rights and obligations in the activity, such as collecting information (formulation of questions) and providing information (the forms in which the information is provided to the patient, such as giving explanations, advice, answering questions), etc. Physicians and patients with different cultural backgrounds might have different views of health and illness as well. The physician-patient relationship might also be influenced by language problems and other cultural differences (e.g., a physician from a country with a larger power distance between physician and patient might try to exercise more control over the interaction compared to a Swedish physician, who might apply a smaller power distance in the consultation). At the same time, the patient, who needs help, is interested in getting the necessary information, a correct diagnosis and treatment. Therefore, one might presume that, in case of communication problems, the Swedish patients, used to a relatively short power distance, might be involved in interaction assisting the non-Swedish physician with problems as well as adapting their language so the physician can understand. These and other issues will be addressed in Chapters 4 to 6.

In this chapter, I will also look at the participants' evaluation of communication, reasons for

lack of satisfaction/dissatisfaction and positive aspects of intercultural medical consultations. Patients' help for physicians and their views of physicians' competence will also be discussed.

I will provide a general analysis of the corpora and a more specific analysis of such aspects of interaction as information seeking (use of questions), information providing (physicians' providing information to patients) and information acknowledgment and checking in intercultural medical encounters in Chapters 5 and 6.

4.2 Views on communication (Non-Swedish physicians and Swedish patients)

In this section, the views on communication of both non-Swedish physicians and Swedish patients are presented. I will discuss the participants' views on what tasks the physician has in meeting a new patient[13], evaluation of communication, reported lack of satisfaction/ dissatisfaction as well as the observed differences in communication between non-Swedish and Swedish physicians (for the Swedish patients) and patients from their home countries versus Swedish patients (for the non-Swedish physicians).

4.2.1 Participants' views of physician's tasks in medical consultation

Both non-Swedish physicians and Swedish patients had to answer a rather similar multiple-choice question about what they think is the most important thing for a physician to do when meeting a new patient (Q.29 for the non-Swedish physicians "What do you think is most important in meeting a new patient?" and Q.23 for the Swedish patients "What do you think is most important in the first meeting with physician? That the physician: …"). The alternatives provided were similar for the non-Swedish physicians and the Swedish patients and concerned such issues as problem solving and showing professional competence ("to solve/solves the patient's/your problems," "to show/shows professional competence," "to take/takes the patient's/your problems seriously"), building relationships and showing interest ("to create/creates a personal relationship," "to show/shows a genuine interest in the patient/you"), communicative behavior ("to address/addresses with the first name," "to make/ makes eye contact," "to greet/greets with a handshake," "to listen/listens"), emotional state and support ("to trust/shows trust," "to be calm/is calm" and "to give confidence/gives confidence"). In addition, the alternative "other" was provided so the respondents could add their comments. The choice of alternatives is the result of the analysis of the interviews, in which the issues mentioned above were raised. All comments were taken into account when analyzing the answers. In Table 25 below, the participants' responses are provided.

13. As I mentioned in the activity coding above, the physician's obligations differ depending on whether it is the first meeting with a patient or not. That is why in my analysis of the respondents' views of what is important in meeting with a patient, I specified that I meant the first meeting with the patient.

Table 25: Non-Swedish physicians and Swedish patients: expectations of physicians (Q. 29 and 23 respectively)

Question	Alternatives/number and %* of respondents per alternative												# of resp.
Non-Swedish physicians: *What do you think is most important in meeting a new patient?* ***Swedish patients:*** *What do you think is most important in the first meeting with physician? That the physician: ...*	to show/ shows a genuine interest in the patient/ you	to create/ creates a personal relationship	to address/ addresses with the first name	to solve/ solves the patient's /your problems	to make/ makes eye contact	to trust/ shows trust	to be calm/is calm	to give confidence /gives confidence	to show/ shows professional competence	to greet/ greets with a handshake	to listen/ listens	to take/ takes the patient's/ your problems seriously	Other	
Non-Swedish physicians	48 56%	29 34%	3 4%	14 16%	26 31%	15 18%	24 28%	44 52%	22 26%	20 24%	55 65%	55 65%	2 2%	85
Male	32 58%	19 35%	3 5%	11 20%	19 35%	10 18%	18 33%	30 55%	17 31%	13 24%	39 71%	36 65%	1 2%	55
Female	16 53%	10 33%	0 0%	3 10%	7 23%	5 17%	6 20%	14 47%	5 17%	7 23%	16 53%	19 63%	1 3%	30
Swedish patients	46 55%	24 29%	16 19%	42 50%	22 26%	25 30%	32 38%	48 57%	34 40%	21 25%	39 46%	57 68%	4 5%	84
Male	23 52%	13 30%	9 21%	26 59%	7 16%	15 34%	17 39%	21 48%	18 41%	12 27%	17 39%	24 54%	1 2%	44
Female	23 58%	11 28%	7 18%	16 40%	15 38%	10 25%	15 38%	27 68%	16 40%	9 23%	22 55%	33 83%	3 8%	40

*Percentages exceed 100% because the total is based on respondents and each respondent was allowed to give more than one response.

To start with **similarities**, as one can see from Table 25, the alternatives "to take/takes the patient's/your problems seriously" and "to show/shows a genuine interest," followed by the alternative "to give confidence/ gives confidence" received the most responses from both the non-Swedish physicians and the Swedish patients. It is interesting that both physicians and patients chose these alternatives more than the ones that concerned professional competence and problem solving. This shows that communication and personal contact are particularly considered important. Looking at the participants' responses to the alternative concerning handshake, one can see that it was chosen roughly equally often by physicians and patients (24% and 25%, respectively).

Concerning **differences**, the non-Swedish physicians value creating a personal relationship (non-Swedish physicians 34%, Swedish patients 29%) and making eye contact (non-Swedish physicians 31%, Swedish patients 26%) somewhat more than their patients. Regarding their views about personal relationships, I presume that a non-Swedish physician, who might experience both a linguistic and a cultural barrier while also being responsible for the interaction, might well consider the relationship with the patient important. Looking more closely at the data, the non-Swedish physicians who chose this alternative include 13 German physicians, 4 respondents from the Middle East, 3 each from Hungary, the Mediterranean region and Eastern Europe, 2 from the former Yugoslavia and one from Northern Europe. Clearly, the respondents' cultural backgrounds vary.

As for eye contact, as I mentioned above, this is something that Swedes often avoid, which may not be the case with the representatives of the cultures to which the non-Swedish physicians belong. This might explain why the Swedish patients are somewhat less likely to mention making eye contact as something the physician should do in the first meeting with a patient. Among the physicians who did choose "eye contact" (26 respondents), 9 are from Germany, 8 from the Middle East, 4 from Eastern Europe, 3 from Hungary and 1 each from the former Yugoslavia and Northern Europe. In Germany, eye contact is appreciated, as it gives the impression of being trustworthy, which may explain why the German respondents chose this alternative. Of the respondents from the Middle East, all the ones who chose eye contact are male. Eye contact is appreciated in the Middle East, but it is gender sensitive.

The Swedish patients were more likely than the non-Swedish physicians to value the physician addressing them by their first name (non-Swedish physicians 4%, Swedish patients 19%). Here, one can observe a sign of the informal Swedish communication style.

Another interesting observation concerns the responses to the alternatives "to solve problems" and "to show professional competence." Both are chosen more by the patients than by the physicians ("to solve problems": non-Swedish physicians 16%, Swedish patients 50%; "to show professional competence": non-Swedish physicians 26%, Swedish patients 40%). I would explain this by the physician's awareness that the patient's problems cannot always be solved, while the patient's aim in seeing a doctor is to have his/her problems solved by the professional. In addition, if one looks more closely at the data, it can be observed that **gender** may be an influencing factor here. The male non-Swedish physicians are more likely than the female physicians to choose the above-mentioned alternatives ("to solve the patient's problems": male non-Swedish physicians 20%, female 10%; "to show professional competence": male non-Swedish physicians 31%, female non-Swedish physicians 17%). In addition, the male Swedish patients chose the alternative "to solve problems" to a greater extent than the female patients (59% compared to 40%). This might

reflect a male problem-solving view of consultation, mentioned in the research on gender and communication presented in Chapter 2. However, looking at the Swedish patients' responses to the alternative concerning professional competence, one can see that it was chosen roughly equally often by male and female patients (41% and 40%, respectively). This may indicate that appreciating a physician's professional competence is not related to gender. Looking closely at which non-Swedish physicians chose the alternative "to show professional competence," the physicians from the countries outside the European Union are over-represented: 9 from Eastern Europe (out of 10 respondents in total), 5 from the Middle East (out of 10 respondents in total), 3 from Germany, and 1 each from the former Yugoslavia, Hungary, Northern Europe, China and Argentina. This may indicate that they feel more need to display their professionalism to their patients than the physicians from the EU/EEA area. In addition, cultural views of the physician's role might play a role here.

The female Swedish patients are more likely than the male Swedish patients to want the physician to make eye contact (female Swedish patients 38%, male Swedish patients 16%), while the opposite is true of the physicians (i.e., the female non-Swedish physicians are less likely than the males to report making eye contact as an important aspect of consultation [female non-Swedish physicians 23%, male non-Swedish physicians 35%]). This might reflect gender-related differences in male and female behavior, as well as cultural differences in how much eye contact is acceptable in relation to gender.

It is interesting to note that the male non-Swedish physicians chose the alternative "to listen" more often than the female physicians (male non-Swedish physicians 71%, female non-Swedish physicians 53%), while the opposite is true for the patients (male Swedish patients 39%, female Swedish patients 55%). I cannot come up with a good explanation for this (one possible explanation is that females speak more and listen less).

Another interesting observation concerning gender differences in views of the physician's tasks concerns creating a personal relationship. Although I will refrain from drawing any definite conclusions, the respondents' answers do not suggest that the female respondents value creating a personal relationship more than the males. This result might appear to contradict the results of earlier research, which shows females as being more likely than males to focus relationship-building behavior, but I am skeptical of this conclusion. First of all, the male respondents might *consider* creating a personal relationship to be as important as females do, but they may not *practice* it in the interaction itself to the same extent. Second, concerning the non-Swedish physicians, when a physician is a foreigner and, as I have mentioned above, experiences cultural and language barriers between himself/herself and a patient, the result might be that both male and female physicians attempt to overcome this barrier and therefore appreciate creating a good relationship with the patient.

Concerning trust, the Swedish patients chose this alternative more often than the non-Swedish physicians (non-Swedish physicians 18%, Swedish patients 30%). I will discuss these differences in more detail in section 4.4 below.

To summarize, both the non-Swedish physicians and the Swedish patients consider the physician's taking his/her patient's problems seriously and showing a genuine interest to be the most important tasks when meeting a new patient. Confidence is also valued by both physicians and patients. Differences in the responses reflect cultural differences; the Swedish patients favor informality (preference for being addressed by their first name) but do not see eye contact as a prerequisite for a physician's making contact with the

patient. The fact that the physicians are foreigners might also mean that both male and female non-Swedish physicians consider creating personal relationships equally important. The observations of male "problem-solving" behavior are consistent with earlier findings. In addition, the respondents' answers reflect the differences in the aims the physician and patient have in a medical consultation. The patient wants to solve his/her problems, while the physician is aware of not always being able to do this.

4.2.2 Participants' satisfaction with communication

Both the non-Swedish physicians and the Swedish patients were asked rather similar multiple-choice questions about their experience of communication (Q.14a in the non-Swedish physicians' and Q.13a in the Swedish patients' questionnaire). However, the alternatives provided to the questions differ.

The non-Swedish physicians were presented with five alternatives, namely "It [communication] is characterized by a mutual command of language and communication," "It is characterized by a mutual cultural understanding," "very satisfactory," "satisfactory" and "less satisfactory." The first two alternatives partially overlap (i.e., one can be satisfied with language and communication, which might also imply cultural understanding); in addition, they both overlap with the alternatives "very satisfactory" and "satisfactory," which might imply (though not necessarily) satisfaction with language, communication and mutual cultural understanding.

Four alternatives – "very satisfied," "satisfied," "less satisfied" and "unsatisfied" – were given to the patients. One of the reasons for giving the physicians more detailed alternatives is a particular interest in non-Swedish physicians' views of language usage and cultural understanding in communication. In addition, the project team attempted to make the patients' questionnaire less complicated, because while the physicians constitute a relatively homogeneous group in terms of education level, the patients' educational backgrounds vary, which might influence their understanding of the questions.

The respondents' answers are presented in Table 26. All comments were taken into account when analyzing the answers.

Table 26: Non-Swedish physicians and Swedish patients: satisfaction with communication (Q.14a and 13a respectively)

Non-Swedish physicians (Q.14a)

Question	**Alternatives/number and %* of respondents per alternative**					**# of resp.**
How do you experience your com munication with Swedish patients?	It is characteri zed by a mutual command of language and communi cation	It is charact erized by a mutual cultural underst anding	Very satisfa ctory	Satis facto ry	Less satis fac tory	
Non-Swedish physicians	35 41%	15 18%	28 33%	38 45%	1 1%	85
Male	27 49%	12 22%	16 29%	22 40%	0 0%	55
Female	8 27%	3 10%	12 40%	16 53%	1 3%	30

*Percentages exceed 100% because the total is based on respondents and each respondent was allowed to give more than one response.

Swedish patients (Q.13a)

Question	**Alternatives/number and % of respondents per alternative**				**# of resp.**
How did you experience your conversa tion [with the non-Swedish physician]?	Very satisfied	Satisfied	Less satisfied	Un satisfied	
Swedish patients	34 40%	29 35%	15 18%	6 7%	84
Male	20 45%	17 39%	7 16%	0 0%	44
Female	14 35%	12 30%	8 20%	6 15%	40

The responses obtained indicate that both the non-Swedish physicians and the Swedish patients are generally satisfied with their communication.

To start with the **physicians**, the alternative "less satisfactory" was chosen only once (1%). The physicians also expressed more satisfaction in terms of language than cultural understanding, as about half of them chose the alternative "it is characterized by a mutual command of language and communication" (41%), while relatively few chose "it is characterized by a mutual cultural understanding" (18%). The alternatives "less satisfied" and "unsatisfied" were chosen by 18% and 7%, respectively, of the **patients** (totaling 25%), which indicates that the patients are more critical of their communication than the physicians.

Turning to **gender**, the female respondents from both groups report lower satisfaction than the male respondents (note that the only non-Swedish respondent who chose the alternative "less satisfactory" was female). Furthermore, the male non-Swedish physicians report being more satisfied with their communication than the female ones when it comes to language and cultural understanding, as they were more likely to choose "it is characterized by a mutual command of language and communication" (male 49%, female 27%) and "it is characterized by a mutual cultural understanding" (male 22%, female 10%). The male patients were also more satisfied than the females, choosing the alternative "very satisfied" to a greater extent (male 45%, female 35%) and such alternatives as "less satisfied" (male 16%, female 20%) and "unsatisfied" (male 0%, female 15%) less frequently.

The Swedish patients were also asked two yes/no questions concerning their satisfaction with regard to expectations (Q.14) and with the amount of information provided (Q.21). The responses to these questions are presented in Table 27.

Table 27: Swedish patients: satisfaction with consultation with regard to expectations and explanations provided by the non-Swedish physicians (Q.14a and 21 respectively)

Q.14a

Question	**Alternatives/number and % of respondents per alternative**		**# of resp.**
Were you satisfied with the consultation with regard to your expectations?	Yes	No	
Swedish patients	65 77%	19 23%	84
Male	39 89%	5 11%	44
Female	26 65%	14 35%	40

Q.21

Question	**Alternatives/number and % of respondents per alternative**		**# of resp.**
Did you get enough with explanations?	Yes	No	
Swedish patients	67 82%	15 18%	82
Male	39 89%	5 11%	44
Female	28 74%	10 26%	38

The table shows that the Swedish **patients** are generally satisfied with consultations with the non-Swedish physicians with regard to their expectations and the explanations provided by the physicians (the answer "yes" to Q.14 and Q.21 was chosen by 77% and 82% of the respondents, respectively).

Concerning **gender**, the female respondents were again more critical than the male ones. Only 11% of males, compared to 35% of female patients, reported not being satisfied with the consultation with regard to their expectations (Q.14) and 11% of males and 26% of females reported a lack of satisfaction with the amount of explanations provided (Q. 21).

Gender combinations might also play a role, as can be seen from Table 28, which shows the Swedish patients' answers to the above-mentioned questions (i.e., Q.13a, Q.14 and Q.21):

Table 28: Swedish patients: evaluation of communication with the non-Swedish physician (same-sex and cross-sex medical encounters, Q.13a, 14a and 21)

Q.13a						Q.14a			Q.21		
Question /gender combination (phs–pat)[14]	*How did you experience your conversation [with the non-Swedish physician]?*					*Were you satisfied with the consultation with regard to your expectations?*			*Did you get enough explanations?*		
	Alternatives/number and % of respondents per alternative				**# of encounters**	**Alternatives/ number and % of respondents per alternative**		**# of encounters**	**Alternatives/ number and % of respondents per alternative**		**# of encounters**
	Very satisfied	Satisfied	Less satisfied	Un satisfied		Yes	No		Yes	No	
M phs–M pat	15 43%	15 43%	5 14%	0 0%	35	32 91%	3 9%	35	30 86%	5 14%	35
M phs–Fpat	12 38%	12 38%	4 13%	4 13%*	32	23 72%	9 18%	32	24 80%	6 20%	30
F phs–F pat	2 25%	0 0%	4 50%	2 25%	8	2 25%	6 75%	8	4 50%	4 50%	8
F phs–M pat	5 56%	2 22%	2 22%	0 0%	9	7 78%	2 12%	9	8 89%	1 11%	9
*The numbers do not add up to 100% because of rounding.											

Though the data are limited and I am unable to draw any definite conclusions, it can be observed that the female patients who experienced communication with a female non-Swedish physician (F phs–F pat) report less satisfaction with their communication than the patients involved in other gender combinations. The alternatives "less satisfied" and "unsatisfied" (Q.13a) received 50% and 25% of responses, respectively (75% in total), for the F phs–F pat gender combination; for Q.14 and Q.21, the alternative "no," which indicated dissatisfaction with the consultation with regard to expectations and the amount of explanations provided received 75% and 50% of the responses, respectively, from the female patients interacting with the female non-Swedish physicians.

On the other hand, the Swedish male patients involved in interaction with male non-Swedish physicians were more satisfied with their communication than the patients in other gender combinations; the responses to Q.13a (M phs–M pat: "less satisfied 14%, "unsatisfied" 0%) and Q. 14 (M phs–M pat: "no" 9%) indicate this. Concerning Q.21, the male patients who had experienced communication with female non-Swedish physicians (F phs–M pat) and male non-Swedish physicians were more satisfied with the amount of explanations provided than the other gender combinations ("no" accounts for 11% and 14%, respectively).

The patients' responses to the above-mentioned questions were also analyzed with regard to **age**, **gender** and **education** (the data are presented in Appendix E). Though there are not enough data to draw definite conclusions, the younger participants (20 to 50 years old) tend to be more critical of their communication with the non-Swedish physicians than the older ones (51 to 90 years old). As for education, none of the Swedish patients with primary education reported being "unsatisfied" with their communication with the non-Swedish

14. phs = physician; pat = patient.

physician. Furthermore, no male patient with primary education reported being "less satisfied" either. The female patients with postsecondary education reported the least satisfaction in general, and with regard to expectations and the amount of explanations in particular.

We shall now examine how the non-Swedish physicians from different cultural backgrounds experience their communication with Swedish patients.

Table 29: Non-Swedish physicians: satisfaction with communication (cultural groups, Q.14a)

Question	**Alternatives/number and %* of respondents per alternative**					**# of resp.**
How do you experience your communication with Swedish patients?	It is characterized by a mutual command of language and communication	It is characterized by a mutual cultural understanding	Very satisfactory	Satisfactory	Less satisfactory	
Germany	15 52%	10 34%	11 38%	15 52%	1 3%	29
Hungary	1 8%	1 8%	5 42%	4 33%	0 0%	12
Northern Europe	3 43%	1 14%	0 0%	5 71%	0 0%	7
Mediterranean	2 25%	2 25%	3 38%	3 38%	0 0%	8
Former Yugoslavia	2 40%	0 0%	0 0%	3 60%	0 0%	5
Baltic States and Eastern Europe	6 60%	1 10%	5 50%	1 10%	0 0%	10
Middle East	6 75%	0 0%	3 38%	5 63%	0 0%	8
Mixed	1 25%	0 0%	1 25%	2 50%	0 0%	4
*Percentages exceed 100% because the total is based on respondents and each respondent was allowed to give more than one response.						

Again, because the number of respondents is low, it is difficult to draw any definite conclusions. However, it can be observed that the Hungarian physicians are least satisfied with their "command of language and communication," as this alternative was chosen by only one respondent. It is primarily the German physicians (34%) who report experiencing mutual cultural understanding in communication with patients. None of the physicians from the former Yugoslavia, the Middle East and the Mixed group reported experiencing cultural understanding (0%). An interesting observation is that none of the respondents from Northern Europe chose the alternative "very satisfactory" to describe their communication, using the more neutral alternative "satisfactory" instead; thus, their expression of satisfaction is rather moderate. However, the respondents from the Baltic States and Eastern Europe, followed by the respondents from Hungary, Mediterranean and the Middle East, mostly chose the alternative "very satisfactory" to describe their communication with their Swedish patients.

I will now summarize and try to explain the findings presented above.

In general, the non-Swedish physicians and the Swedish patients are satisfied with their communication. The Swedish patients are more critical than the non-Swedish physicians.

Although the picture concerning satisfaction is generally positive, one might of course question whether the questionnaire reliably reveals to what extent the respondents' choices reflect actual rather than desired experiences as well as whether the number of informants is high enough to draw any definite conclusions. One should also bear in mind the fact that, in spite of the promise of anonymity, the respondents might still feel insecure.

At the same time, a number of other factors might be influential here as well. The non-Swedish physicians might be willing to present a positive picture in an attempt to show their successful integration and thus be less inclined to report communicative failure. Conversely, the Swedish patients might see this questionnaire as an opportunity to provide information that might improve health care services (one of the patients commented in the interview: *Bra undersökning. Kul att någon uppmärksammar problemet* ('Good research. Nice that someone is paying attention to the problem.'). Furthermore, a cultural factor, namely a common stereotype about Swedes being honest to and critical of authorities, may play a role here as well. On the other hand, patients might hesitate to express any negative thoughts they might have for fear of being seen as racists and therefore they might give more neutral answers. In addition, one of the typical features of Swedish mentality, namely conflict avoidance and neutrality (Phillips-Martinsson, 1992; Daun, 2005), may influence both how this group answers the questions and their communication overall.

The non-Swedish respondents are more likely to experience their communication as being characterized by a mutual command of language rather than cultural understanding. The Hungarian physicians are least satisfied with their command of language and communication. The German physicians report most satisfaction with mutual cultural understanding. The physicians from Northern Europe evaluate their communication with the Swedish patients as "satisfactory," being moderate in their expression of satisfaction.

In general, one can see that the physicians feel more comfortable with language than with the cultural aspects of communication. The Hungarian physicians' lower satisfaction with language compared to other respondents is probably related to their being the group that has spent the least time in Sweden, which may influence their level of language competence. The German physicians' higher satisfaction with their cultural understanding may tentatively be explained by the closeness of German and Swedish culture. The fact that the North European physicians are moderately satisfied with their communication I would explain by the tendency to understate rather than overstate, which is common in the Nordic cultures. In addition, the high satisfaction level reported by the German and Hungarian respondents might also be explained by the fact that they were recruited from within the European Union, so their medical education is automatically approved in Sweden and their workplaces are guaranteed. This safety might lead to heightened satisfaction compared to the non-European physicians, who have to overcome significantly more obstacles on their way to the Swedish workplace.

Concerning gender, the female respondents, both physicians and patients, are more critical than the male respondents concerning communication. Moreover, the female patients also tend to be more critical about communication with female non-Swedish physicians than the male ones; the male patients show somewhat higher satisfaction communicating with male physicians than with female physicians.

One possible explanation of the observed gender differences might be the differences

between male and female communicative styles, and in particular females' higher demands for affective communication and interpersonal relationships in general, and in our case with their patients or physicians in particular (see Chapter 2).

Developing relationships across linguistic and cultural borders could be problematic. Consider this comment from a female patient: *Svårt att tala med utländsk läkare om problem som rör psyket. Utmärkt bra när det rör fysiska problem* ('Difficult to talk to non-Swedish physicians about psychological problems. Excellent concerning physical problems.'). This is related to Steward's (2003) comment concerning IMG in the USA:

> patients may sense that, in comparison with U.S. residents, international residents [IMG], even though fluent in English, are not at ease talking with them about personal matters and do not fully comprehend their concerns about their illness and medical care.
>
> (Steward, 2003, p. 82)

The physicians in our study report female patients to be more demanding than male patients (similar findings were reported by Foss and Sundby, 2003). The male Swedish physician SweD9 considers male patients to be "easier" than female ones:

Som manlig läkare lättare att tala med en annan manlig patient.	*As a male doctor, easier to talk to another male patient.*

The female patients might expect female rather than male physicians to have a greater ability to talk about psychosocial matters. Thus, when a female physician fails to build this psychosocial communication with her female patient, due to language problems or cultural differences (or both), it might result in the patient's experiencing and expressing more disappointment than in a similar situation with a male physician, from whom she has lower expectations concerning psychosocial talk. This might be reflected in the reported higher occurrence of cultural differences (which are often associated with problems) and lower patient satisfaction in F phs–F pat consultations than in the other gender combinations (see Table 28).

At the same time, a cultural factor might be influential here as well. Consider a comment from the Iranian female physician IraD10 (a small dark-haired woman) on this issue:

Om du är man och utländsk så går det kanske lättare eftersom överhuvudtaget bilden av en bra läkare kanske är man lite stor och stark och lite vitt hår och lite mage och förstås svensk det är inte bilden alla patienter ser hos mig.	*If you are a man and a foreigner, it may be easier since on the whole the picture of a good physician maybe is a man somewhat big and strong and some white hair and a bit of a belly and of course Swedish; this is not the picture all patients see in me.*

This is also observed by a male Swedish physician (SweD9), who points out more problems that the female physicians in general, and female non-Swedish physicians in particular face, especially when talking to elderly patients:

Svårare som kvinnlig läkare eftersom läkaryrket är manligt från början. [Äldre patienter] tror inte att hon är läkare utan en sköterska om det kommer en kvinnlig läkare. En ung kvinnlig läkare – då kan de ingenting. Många äldre människor har fördomar.	*More difficult for a female physician as the medical profession is masculine from the beginning. [Elderly patients] don't believe that she's a doctor but a nurse if a female doctor arrives. A young female physician – they know nothing. Many elderly people have prejudices.*

All these factors can result in the female patients expressing less satisfaction than the male ones concerning their communication with non-Swedish physicians.

Younger and better-educated patients are more critical than older and less-educated patients.

This conclusion is highly tentative due to the low number of respondents. However, it is supported by, among other things, the following comment from a Swedish male senior physician (SweD10) concerning the patient's age:

För femtio år sedan då var man GUD som doktor i Sverige. Det är det inte längre, de anmäler doktorer för att de gjort fel osv. Amnälningar från patienter till doktorer har ökat mycket och det är inte att de gör mer fel utan att patienter accepterar inte det längre. Bemötandet som irriterar folk mycket inte tekniska fel så mycket utan att man kunde inte kommunicera riktigt.	*Fifty years ago, one was GOD as a doctor in Sweden. It's not like this any more, they report doctors because they've made a mistake, etc. Reports from patients have increased a lot and it's not that they make more mistakes, but that the patients don't accept it any longer. The treatment that irritates people a lot not technical mistakes so much but that one couldn't communicate properly.*

Older patients' higher satisfaction might be due to they greater respect they are accustomed to give the physician compared to the younger generation, as "older people learned the patient role prior to the emergence of consumerism, in en era when patients were more deferential to physicians' status" (Cline and McKenzie, 1998, as cited in Bradley et al., 2001, p. 1752). Bradley et al. (2001) also mention the studies of Haug and Lavin (1981) and Beisecker (1988), which point out that older patients are more likely than younger ones to accept the traditional asymmetry in doctor-patient power relations; they also tend to be less involved in decision-making. The fact that older patients are usually more satisfied with their physicians than younger ones is even mentioned in a recent study by Duberstein et al. (2007). A male physician from Iraq (IraqD14) says that younger patients are able to understand non-Swedish physicians more easily, but are more critical. At the same time, elderly patients often show more respect and patience, although they experience more problems with understanding, due to, for example, hearing problems (see section 4.3.3).

Concerning education, one might speculate that a higher level of education places the patient in a more equal position with the physician, which allows the patient to be more critical. A comment from a Hungarian female physician (HuD2) supports this claim, as well as the observations concerning gender mentioned above:

Svenska patienter är mer krävande, mer kvinnor, särskilt lärare, mer kvinnor än men.	*Swedish patients are more demanding, more women, especially teachers, more women than men.*

In the next section, I will go into more in detail on the participants' reasons for a lack of satisfaction/dissatisfaction with communication, but first I will present the non-Swedish physicians' views of differences in communication between patients from their respective home countries and Swedish patients, and the Swedish patients' experiences of differences communicating with Swedish and non-Swedish physicians.

4.2.3 Comparison of communication – Swedish and non-Swedish physicians and Swedish and non-Swedish patients

The non-Swedish physicians were also asked to compare communication with patients from Sweden and from their respective home countries. Their responses are provided in Table 30. A few non-Swedish physicians chose more than one alternative (commenting on the differences); consequently, the percentages reported exceed 100% when summed for all possible answers to a question.

Table 30: Non-Swedish physicians: differences in how patients talk to physicians in home countries and Sweden (Q. 23)

Gender

Question	**Alternatives/number and %* of respondents per alternative**				**# of resp.**
Are there any differences in how Swedish patients talk to you compared to the patients from your home country?	Yes	No	If yes, what?	No experience	
Non-Swedish physicians	45 56%	35 43%	1 1%	0 0%	81
Male	26 49%	27 51%	1 2%	0 0%	53
Female	19 70%	8 30%	0 0%	0 0%	27
*Percentages exceed 100% because the total is based on respondents and each respondent was allowed to give more than one response.					

Cultural groups

Question	**Alternatives/number and %* of respondents per alternative**				**# of resp.**
Are there any differences in how Swedish patients talk to you compared to the patients from your home country?	Yes	No	If yes, what?	No experience	
Germany	20 71%	8 29%	0 0%	0 0%	28
Hungary	1 10%	9 90%	0 0%	0 0%	10
Northern Europe	2 29%	5 71%	0 0%	0 0%	7
Mediterranean	4 50%	4 50%	0 0%	0 0%	8
Former Yugoslavia	4 90%	1 10%	0 0%	0 0%	5
Eastern Europe	6 60%	4 40%	0 0%	0 0%	10
Middle East	6 60%	3 30%	1 10%	0 0%	10
Mixed	2 50%	2 50%	0 0%	0 0%	4
*Percentages exceed 100% because the total is based on respondents and each respondent was allowed to give more than one response.					

More than half of the non-Swedish respondents (56%) report experiencing differences

between how Swedish patients talk to them and how patients talk to them in their country of origin. This is especially true of the female respondents (female 70% compared to male 49%). Concerning differences in answers according to cultural groups, the physicians from the former Yugoslavia and Germany are more likely than the respondents from other groups to report experiencing differences in patients' way of communicating in Sweden compared to their home countries (90% and 71%, respectively), while the opposite is true of the Hungarian and North European physicians (10% and 29%, respectively, chose "yes"). Few respondents commented on what specific differences they had experienced. The comments provided concerned the Swedish patients' better knowledge of diseases, differences in the relationship between physician and patient, and experience of language problems. I will discuss these differences in more detail in section 4.3 below.

Similarly, the Swedish patients were asked whether they experienced any cultural differences in communication with the non-Swedish physicians. The responses are presented in Table 31.

Table 31: Swedish patients: cultural differences in interaction with non-Swedish physicians (Q.19)

Gender

Question	**Alternatives/number and %* of respondents per alternative**			**# of resp.**
Did something occur in your meeting [with the non-Swedish physician] that indicates cultural differences?	Yes	No	If yes, please comment	
Swedish patients	14 18%	62 82%	5 7%	76
Male	4 10%	38 91%	0 0%**	42
Female	10 29%	24 71%	5 15%	34
*Percentages exceed 100% because the total is based on respondents and each respondent was allowed to give more than one response. **The numbers don't add up to 100% because of rounding.				

Same-sex and cross-sex medical encounters

Question	**Alternatives/number and %* of respondents per alternative**			**# of encounters**
Did something occur in your meeting [with the non-Swedish physician] that indicates cultural differences?	Yes	No	Comment	
M phs–M pat	3 9%	30 91%	0 0%	33
M phs–Fpat	8 25%	19 59%	5 16%	32
F phs–F pat	2 29%	5 71%	0 0%	7
F phs–M pat	1 11%	8 89%	0 0%	9
*Percentages exceed 100% because the total is based on respondents and each respondent was allowed to give more than one response.				

The majority of the Swedish **patients** (82%) report not experiencing any cultural differences in communication with non-Swedish physicians. One can observe that the female patients report more cultural differences than the male patients (female 29%, male 10%); they also add more comments to supplement their answers (female 15%, male 0%). Furthermore, the female patients involved in female-female interactions (F phs–F pat) report more cultural differences than the other gender combinations (29%). The fewest differences are reported by the male patients in male-male interactions (M phs–M pat 9%).

No clear tendencies can be observed concerning the patients' **age** and **education** and their experience of cultural differences. More older than younger male patients report experiencing cultural differences in communication with non-Swedish physicians, while the opposite is true of the female respondents. The respondents with secondary education, both male and female, are more likely than other participants to report experiencing cultural differences (see

Appendix E).

To sum up, the non-Swedish physicians in general report experiencing differences in communication with patients in Sweden and in their home countries. The female respondents are more likely than the males to report differences in how Swedish patients talk to them.

The same tendency as observed above, namely the female respondents are more critical and more sensitive to communication than the male respondents, can be seen here.

The representatives from the former Yugoslavia and Germany report experiencing the most differences while the Hungarian and North European physicians note the fewest.

While it is not surprising that the North Europeans experience few differences, Hungarian and German physicians' responses are more difficult to explain. It is interesting that the German physicians, who were among those who reported the most satisfaction with communication when it comes to mutual cultural understanding, were also among those who reported experiencing the most differences. One can deduce that experiencing differences does not necessarily lead to lower satisfaction; it might depend upon whether the differences that result in changes in communication are "better" or "worse" for the respondents. I will return to the German physicians' reported differences in the next section (4.3). I am unable to provide a good explanation of why the Hungarian physicians report experiencing the fewest differences in communication.

The majority of the Swedish patients experience no cultural differences in communication with the non-Swedish physicians. The female patients report experiencing more cultural differences than the male ones, especially in consultations with female physicians, while the male patients experience the fewest differences in communication with the male physicians.

Cultural differences are less "visible" than language problems. This may partially explain why few patients report experiencing cultural differences in their interactions. At the same time, one might presume that cultural differences may not have enough impact on interaction to be reported by the patients. The same tendency concerning gender can be observed as we have seen several times before: the female respondents were more sensitive to communication issues than the male respondents.

4.3 Reasons for lack of satisfaction/dissatisfaction with communication: language problems and cultural differences experienced by the participants

The participants were asked about the reasons for any lack of satisfaction/dissatisfaction with communication, as well as the problems experienced in communication, in both the interviews and the questionnaires.

The non-Swedish physicians emphasized that most communication problems occurred at the beginning of their work in Sweden due to work overload, experiencing a new environment and unfamiliar routines. In addition, their problems using Swedish in the workplace, outside the classroom, were mentioned. The Finnish chief senior physician (FinD22), who had extensive experience of both working with non-Swedish physicians and being one, comments:

> Det är hemskt mycket nytt även om du principiellt behandlat samma sjukdom precis på samma sätt i Iran än i Sverige. Medicinerna heter annat, du använder lite annan journal. I grund och botten är det kanske samma medicin som du använder, med det är hemskt mycket som du ska lära dig nytt.
>
> *A lot of things are new even if you, in principle, treated the same disease in the same way in Iran as in Sweden. Medicines have different names, you use slightly different files. Basically, it may be the same medicine that you use, but there are a lot of new things that you have to learn.*

Apart from the high work tempo, responsibility and language problems, being "inspected" at workplace by colleagues was also mentioned. The Iranian physician IraD6 comments:

> När jag började med min provtjänstgöring ... när jag började där kunde kanske 50-60% av vad de sade och samtidigt måste prata med patient, personal, kunna rutiner och det vara bara hemskt kan man säga. Många saker på en gång. Man har ansvar och lära sig saker på en gång och de [personal] tittar vad du gör, det var inte så behagligt känsla kan man säga.
>
> *When I started my trial period ... when I started there, I could understand maybe 50-60% of what they said and at the same time had to talk to patient, staff, know the routines, and it was simply terrible you could say. Many things at once. One has both responsibility and to learn things at once and they [medical personnel] look at what you do; it wasn't a very pleasant feeling, you could say.*

In the questionnaires, a few non-Swedish physicians (three females, from Germany, Hungary and Romania) and a few Swedish patients answered the questions concerning the reasons for lack of satisfaction/dissatisfaction with communication (Q.14b and Q.13a respectively). In both cases, problems with understanding and word-finding problems were mentioned. The Swedish patients' responses are presented in Table 32.

Table 32: Swedish patients: reasons for lack of satisfaction with communication with non-Swedish physicians (Q.13b)

Question	**Alternatives/number and %* of respondents per alternative**							**# of resp.**
If you answered less satisfactory/ unsatisfactory, the reason was that	the physician was difficult to understand	the physician had difficulties pronouncing some words	the physician had difficulties finding some words	the physician had difficulties making sentences	the physician had difficulties seeing if you had understood	the physician had difficulties understanding implied information	Other	
Swedish patients	10 48%	7 33%	5 24%	3 14%	6 29%	12 57%	5 24%	21
Male	4 67%	2 33%	0 0%	1 17%	1 17%	3 59%	0 0%	6
Female	6 40%	5 33%	5 33%	2 13%	5 33%	9 60%	5 33%	15
* Percentages exceed 100% because the total is based on respondents and each respondent was allowed to give more than one response.								

Problems with understanding in general and with understanding of implied information in particular are the most common responses given by the patients (48% and 57%, respectively). More female than male respondents made comments on communication difficulties ("Other": female 33%, male 0%) and on word-finding problems (female 33%, male 0%). The alternative "Other" includes comments on the physician's attitude (*attityd* ['attitude'], *Var nonchalant. Ville ej lyssna* ['Was nonchalant. Didn't want to listen.']), and tempo of conversation (*pratade för fort* ['talked too quickly']).

Below, I will present in more detail the communication problems between the non-Swedish physicians and their Swedish patients that received the highest number of comments.

4.3.1 Being too brief: a consequence of lack of language competence, cultural difference or both?

One of the consequences of the non-Swedish physicians experiencing language problems is their being too brief, not detailed enough in their communication, especially when they had just started to work in Sweden, reflected in such comments from the physicians as *i börja strukturerad [kommunikationsstil], målinriktad, slutna frågor* ('at the beginning structured [communication style], goal-oriented, closed-ended questions'), *inskränkt pga. språkliga problemer* ('restricted due to language problems'). This can be a drawback when the diagnosis is serious and it is necessary for the physician to expand on the explanation he/she gives the patient (SweD9):

> Osäker på språket – en del blir då väldigt kortfattade. Om det är ett negativt besked – bra att försöka brodera ut svaret så det inte känns så hårt för patienten.
>
> *Unsure about language – some become very short then. If it's a negative answer – good to embellish the answer so it doesn't feel so hard for the patient.*

Being too brief might result in being perceived as harsh and unethical. In Sweden, indirect communication is common, while more direct communication is acceptable in other cultures such as Germany (Lewis, 2000). Being indirect might be complicated for the non-Swedish physicians due to their language problems, as well as their unawareness of this feature of

Swedish culture. It is commented on by the Finnish physician FinD22:

man är inte så rak med sin kommunikation [i Sverige] man pratar "bredvid" varandra lite grann. Man vill inte såra varandra. Det här är att jag tycker så här, och vad tycker du då?	*you're not very direct in your communication [in Sweden], you talk somewhat "beside" each other. You don't want to hurt each other's feelings. This is that I think like this, and what do you think?*

The example below illustrates a German physician being rather direct in how he delivers information to his patient concerning treatment and need for care:

Example 1. "You don't need care" (GerD12)

Prescription. Planning the treatment process

Speaker	**Transcription**	**Translation into English**
$D:	du har aldrig haft så mycke / e / du har alltid inte så mycke // e jag menar med med < fastställbara > förändringar // tekniska // (...) // **du behöver < inte vård** // >	*You've never had so much / er / you've always not so much // I mean with with < establishable > changes // technical // (...) //* ***you < don't need care >***
@ < pronunciation: fästställbara/establishable > @ < laughing >		
$P:	ja	*yeah*
$D:	e men du skall kontakta kurator	*er but you should contact a welfare officer*
$P:	m	*mhm*
$D:	det hjälper / ibland // inte	*it helps / sometimes // not*
$P:	va ska ja säga till kuratorn då	*what should I say to the welfare officer then*
$D:	**vad du vill**	***whatever you want***
$P:	men va < k+ > va kan hon göra // [ta kontakt] me försäkringskassan	*but what <c+ >what can she do // [get in contact] with the regional social insurance office*
@ < cutoff: kan / can >		
$D:	[ja]	*[yeah]*

The physician is apparently experiencing problems formulating his message while trying to say that he has not observed any established changes. The fact that he considers that the patient does not need care is expressed directly (*du behöver inte vård* ['you don't need care']). One can also see that the patient is embarrassed at this, as well as at the physician's answer to her question concerning consultation with a welfare officer. The patient's question (*vad ska jag säga till kuratorn då* ['what should I say to the welfare officer then']) which includes the particle *då* ('then') reflects the patient's skepticism of the physician's recommendation and her anticipated disapproval of his answer to her question (see Eriksson, 1988, for the discussion of *då* in questions). It could also represent a conclusion and/or slight opposition from the patient.

In the interviews, the non-Swedish physicians comment on the need to provide more information and to be more detailed and exhaustive in talking to the Swedish patients compared to the patients in their home countries. The Swedish patients are reported to be more demanding and more knowledgeable; they are well prepared before the meeting with the physician compared to patients from some of the non-Swedish physicians' home

countries (primarily mentioned by physicians who come from countries that are at a lower level of economic development compared to Sweden; a similar observation was made by Lockyer et al., 2007). Comments include *svenska patienter vet mer om sin sjukdom* ('Swedish patients know more about their disease'); *svenska är mer högutbildade och mer krävande* ('the Swedes are more educated and more demanding'); *svenska patienter är mer utbildade och frågar oftare än patienter i hemlandet* ('the Swedish patients are more educated and ask questions more often than the patients in my home country'). Access to the Internet and relevant literature and a higher education level in society are influential factors, for example, *de [patienterna] sitter, tittar i datorn surfar sajtar å vet jättemycket nya behandlingar och det är bra tycker jag* ('they [the patients] sit, look at the computer surf sites and know a huge lot of new treatments and that's good I think'). Consider the comment below from a physician from the former Yugoslavia (YugD19):

Jag pratade med en ung kvinna som kunde välja ryggbedövning eller narkos vanlig narkos och hon frågade alla möjliga saker mig vad är statistiken? vad visade socialstyrelsen? varför är ryggbedövning bättre? varför inte? hur mycket har positiva hur mycket har negativa sidor? osv. För mig var det jättesvårt.	*I talked to a young woman who could choose spinal anesthesia or general anesthesia, ordinary anesthetic and she asked me all kinds of things: what's the statistics? what did the National Board of Health and Welfare show? why is spinal anesthesia better? why not? how many have positive, how many have negative sides? etc. For me it was very difficult.*

In addition, such cultural factors as power distance differences might be relevant here. Sweden is characterized by a relatively small power distance compared to the majority of countries the non-Swedish physicians come from. As mentioned above, the PDI is relatively low for Sweden (31) compared to the homelands of the non-Swedish physicians (e.g., Colombia [67], Germany [35], Hungary [46], Iran [58], Poland [68], and Russia [93][15]). Swedish patients are often reported to want to be involved in decision-making; the physician does not have "the sole right" but is expected to provide all the necessary information to the patient. The physician from Iraq (IraqD14) comments:

Patienter är inte tysta i Sverige. De vill ha förklaring, vad vi gör ... läkare ska vänta 10 frågor, och ha svar på 10 frågor.	*Patients are not quiet in Sweden. They want explanation, what we do ... physicians should expect 10 questions, and have answers to 10 questions.*

The "Swedish consultation" is often a relatively informal meeting, with the physician being more an advisor than an authority, and the patient being expected to take responsibility for his/her own treatment, for example, *mindre mentalt avstånd mellan patient och läkare* ('shorter mental distance between patient and physician'), *mer jämställd* ('more equal'); *mer informell* ('more informal'), *i Sverige vänligare relation mellan patient-läkare* ('in Sweden friendlier relationship between patient-physician').

15. Estimated values for Hungary, Iran, Poland and Russia, obtained from Hofstede and ITIM (no date).

Consider the example below, an excerpt from a consultation between a Swedish female surgeon and a Swedish male patient, in which the physician informs the patient about possible surgery for removing the gall bladder, explaining the pros and cons:

Example 2. "It is you who decides" (SweD7)

Physician and patient discussing surgery

Speaker	Transcription	Translation into English
$D:	så har man haft nåra av dom här tre e grejerna **då brukar man REKOMMENDERA operation** / har man bara haft gallstensattacker då får man välja lite själv hur besvärlit man tycker de e / å hur mycke de inskränker på ens livskvalitet men om man har haft dom här lite allvarliare grejerna me en inflammation i gallblåsan eller en retning på bukspottkörteln eller stopp i gallgångarna eller så då brukar man rekommendera att man tar bort gallblåsan // e för de e lite allvarligare än ett vanlit gallstensanfall // men sen e man ju förstås den som operationen ska utföras på **de e ju du som ska leva me de så du har ju medbestämmanderätt eller rättare sagt de e du som bestämmer men de vet du säkert om**	*so if one has had some of these three things then **we usually RECOMMEND surgery** / if one has had attacks of biliary colic then one may choose a little oneself how troublesome one thinks it is / and how much it limits one's quality of life but if one has had these somewhat more serious things with inflammation of the gallbladder or irritation in the pancreas or stoppage in the bile ducts or something like that we usually recommend removing the gall bladder // er because it's somewhat more serious than an ordinary attack of biliary colic // **but then again you are the one who will undergo surgery you are the one who will live with it so you have of course the right to participate in the decision or to be more correct it's you who decide but surely you know that***

This example illustrates the Swedish physician's emphasis on seeing herself primarily as an advisor, whose task is to inform the patient, while allowing him to make his own decision. Note the physician's emphatic stress on the word *REKOMMENDERAR* ('RECOMMENDS') as well as her mention of the patient's right to participate in the decision-making.

The example above can be contrasted to the example below, an excerpt from the interaction between an Iranian physician and his Swedish patient. In cultures that have a larger power distance, the physician functions more as an authority than as an advisor. The Iranian physician attempts to calm down his patient, who demands immediate hospitalization:

Example 3. "Working as doctor" (IraD8)

At the end of consultation, the patient insists on being hospitalized

Speaker	Transcription	Translation into English
$D:	per-oskar de går inte de e så här inte fungerar hälsovården // de är ju inte så att du kommer å säger att ja vill bli inlagd va / **de e ju de e ju vi som ska bedöma om du litar på oss arbetar som doktor ja säger att de bästa för dej de e ju som ja < s + > gör va** // men om du vill liksom påverka själv // då de en helt annan sak ja förstår att du har ont / [1 de]1 e därför ja reagerar annars skulle [2 (...)]2	*per-oskar it doesn't work it's like this health care does not function // you know it's not like you come and say that I want to be hospitalized right **/ you know you know we are the ones who decide if you trust us working as doctor I say that the best for you it's of course what I <s + > do right //** but if you want to kind of influence yourself // then it's a quite different thing I understand that you're in pain / [1 that's]1 why I react otherwise would [2 (...)]2*
@ < cutoff: säger/say >		
$P:	[1 ja]1	*[1 yeah]1*

$P:	[2 jo jo]2 ja fattar vidden att // varför ja ska hållas (...) nu // du har konstaterat att ja har kula i axeln / så va e problemet skär bort den å ta bort den	*[2 well well]2 I understand the extent that // why I should be kept (...) now // you have stated that I have a bullet in my shoulder / so what's the problem, cut it out and remove it*

In this discussion, the physician attempts to use his position as a professional to persuade the patient, but this argument apparently does not have any effect. Situations like this often result in the physician's feeling that he/she is not respected and the patient's questioning his/her authority (see also Berbyuk, 2005). Behjati-Sabet and Chambers (2005) specifically emphasize the importance of trust for Iranian patients in their communications with Iranian physicians; this trust must be established during the first few visits. The authors point out that:

> Once this [trust] is achieved, the patient becomes a "believer" in his or her doctor. This is a notion commonly held by Iranians, and once fulfilled, will very likely cause the patient to follow the physician' s advice. Trusted and "believed in" doctors are regarded as definite authorities, or parental figures, and older male doctors are more readily trusted.
>
> (Behjati-Sabet and Chambers, 2005, p. 150)

The patient's lack of trust in the physician in the situations as above might be a sensitive experience for the physician.

The difference in authority and the physician's role are also reflected in the example below, an excerpt from the interaction between the female Russian physician and a Swedish male patient (adapted from Berbyuk, 2005):

Example 4. "Fibrillations" (RusD18)

Patient inquiring about fibrillations

Speaker	**Transcription**	**Translation into English**
$D:	som sagt att hjärtat e / som tidigare inga förändringar men vi kan ta < ekg >[16]	*as I said before your heart is / like before no changes but we can do an < ecg >*
@ < abbreviation >		
$P:	a e hur hur konstaterar man nä de nä de e flimmer i hjärtat	*yeah er how how do you know when there when there are fibrillations in the heart*
$D:	ah att hjärtat slåss oregelbundet det kan man höra både med stetoskop och på < ekg >	*well when the heart beats irregularly you can hear it both with a stethoscope and on the < ecg >*
@ < abbreviation >		
$P:	**de e / de e de e tack vare flimmer**	***that's / that's thanks to fibrillations***
$D:	**a precis du har flimmer men normal frekventa flimmer**	***yeah exactly you have fibrillations but normal frequency fibrillations***
$P:	**a ja ha då flimmer då**	***yeah I have fibrillations then***
$D:	**a nu vill jag se rörlighet i axeln**	***yeah now I want to see the movability of your shoulder***

16. ECG is the acronym for electrocardiogram.

The physician provides an explanation, but ignores the patient's subsequent anxious remark about having fibrillations, continuing with the examination. The physician seems to attach more importance to conducting a thorough examination than to talking to the patient and providing a detailed answer to the question.

Difference in power distance is one of the main cultural factors influencing communication between the non-Swedish physicians and their Swedish patients. The question arises: Do the non-Swedish physicians change their communicative style? As the power distance differences are clearly reflected in formality, the non-Swedish respondents were asked in the questionnaire if they had changed their communicative style (by becoming more informal or formal) (Q.24. "Has your communicative style in consultations with patients in Sweden changed compared to how it was in your home country?" with the alternatives "has become more informal," "has become more formal," "unchanged," "no experience" and "other," and some space for comments). The Swedish patients were also asked to compare Swedish and non-Swedish physicians' communication styles in regard to formality (Q.30 "Do you think that non-Swedish physicians' communicative style, compared to Swedish physicians' communicative style, is: …" with the alternatives "more informal," "more formal," "no difference," "other," "don't know"). The responses are presented in Table 33 below.

Table 33: Non-Swedish physicians: change in communicative style, and Swedish patients: differences in communicative style between Swedish and non-Swedish physicians (Q.24 and Q.30 respectively)

Non-Swedish physicians (Q.24)

Question	**Alternatives/number and % of respondents per alternative**					**# of resp.**
Has your communicative style in consultations with patients in Sweden changed compared to how it was in your home country?	Has become more informal	Has become more formal	Unchanged	Other	No experience	
Non-Swedish physicians	19 24%	11 14%	41 51%	5 6%	4 5%	80
Male	10 19%	5 10%	29 56%	5 10%	3 6%*	52
Female	9 32%	6 21%	12 43%	0 0%	1 4%	28
*The numbers do not add up to 100% because of rounding.						

Swedish patients (Q.30)

Question	**Alternatives/number and % of respondents per alternative**					**# of resp.**
Do you think that non-Swedish physicians' communicative style, compared to Swedish physicians' communicative style, is	More informal	More formal	No difference	Other	Don't know	
Swedish patients	10 12%	19 23%	35 43%	2 2%	16 20%	80
Male	4 9%	9 21%	20 46%	2 5%	8 19%	43
Female	4 11%	10 27%	15 41%	0 0%	8 22%*	37
*The numbers do not add up to 100% because of rounding.						

About half of the non-Swedish **physicians** consider that they have not changed their communicative style (51%). Of those who have changed, more became more informal than more formal (24% compared to 14%). More female than male participants indicated changing their style of communication with patients, becoming either more informal (female 32%, male 19%) or more formal (female 21%, male 10%).

Among the Swedish **patients**, 43% experienced no difference in communicative style between Swedish and non-Swedish physicians, while 12% of the patients reported the non-

Swedish physicians to have a more informal and 23% a more formal communicative style than Swedish physicians. Concerning **gender**, somewhat more male than female respondents chose "no difference" (46% compared to 41%) and somewhat more female than male patients experienced the non-Swedish physicians as being more formal than the Swedish ones (27% compared to 21%). Older and less-educated patients are more likely than the younger and more-educated patients to report experiencing no difference between non-Swedish physicians' and Swedish physicians' communicative styles.

Concerning the patients' responses on the issue of the formality/informality of non-Swedish physicians communicative style in cross-sex and same-sex medical encounters, the following picture emerges:

Table 34: Swedish patients: difference in communicative style between Swedish and non-Swedish physicians (same-sex and cross-sex medical encounters, Q. 30)

Question	**Alternatives/number and % of respondents per alternative**					**# of encounters**
Do you think that non-Swedish physicians' communicative style, compared to Swedish physicians' communicative style, is	More informal	More formal	No difference	Other	Don't know	
M phs–M pat	4 10%	6 15%	17 44%	2 5%	10 26%	39
M phs–Fpat	4 13%	8 26%	11 35%	0 0%	8 26%	31
F phs–F pat	0 0%	2 33%	4 67%	0 0%	0 0%	6
F phs–M pat	0 0%	3 33%	3 33%	1 11%	2 22%*	9
*The numbers do not add up to 100% because of rounding.						

It is interesting that none of the Swedish patients experienced female non-Swedish physicians as being more informal than female Swedish physicians, while 33% of both male and female patients consider female non-Swedish physicians to be more formal than female Swedish physicians.

Concerning the responses of the non-Swedish physicians from the various cultural groups, Table 35 presents the following picture:

Table 35: Non-Swedish physicians: change in communicative style (cultural groups, Q.24)

Question	Alternatives/responses					# of resp.
Has your communicative style in consultations with patients in Sweden changed compared to how it was in your home country?	Has become more informal	Has become more formal	Un changed	Other	No experience	
Germany	8 30%	2 7%	14 52%	3 11%	0 0%	27
Hungary	4 40%	1 10%	5 50%	0 0%	0 0%	10
Northern Europe	0 0%	0 0%	6 90%	0 0%	1 10%	7
Mediterranean	3 50%	2 33%	1 17%	0 0%	0 0%	6
Former Yugoslavia	1 20%	2 40%	2 40%	0 0%	0 0%	5
Baltic States and Eastern Europe	2 22%	2 22%	5 56%	0 0%	0 0%	9
Middle East	1 10%	2 20%	4 40%	1 10%	2 20%	10
Mixed	0 0%	1 25%	2 50%	1 25%	0 0%	4

The majority of the physicians from Northern Europe and the Baltic States and Eastern Europe reported not changing their communicative style, choosing the alternative "unchanged" (90% and 56%, respectively). About half (52%) of the German physicians had not changed their communicative style; 30% reported becoming more informal. The physicians from the Mediterranean group and Hungary reported becoming more informal in their communication with patients (50% and 40%) while about half of the respondents from the former Yugoslavia considered themselves to have become more formal (40%).

To summarize the above discussion, the following observations can be made:

The non-Swedish physicians' language problems, combined with differences in power distance, result in the physicians' being too brief in their communication with patients. The majority of the non-Swedish physicians who had changed their communicative style had become more informal. Female physicians reported changing their style more than males.

The responses indicate that the non-Swedish physicians tend to become more informal, which can be explained by their adaptation to differences in power distance. The females, as mentioned above, are more sensitive to communication issues and this might explain why the female non-Swedish physicians changed their style more than their male counterparts.

In general, the Swedish patients experience no difference between the Swedish and non-Swedish physicians' communicative styles. This is especially true of older patients with primary education. Many of those who state that there is a difference evaluate the non-Swedish physicians' style as being more formal than that of Swedish physicians. Male patients report experiencing differences to a lesser extent than females.

Similarly, as I have mentioned, the female patients appear to be more sensitive to

communication. The younger and more educated patients appear to experience more differences than the less-educated patients, probably because they are more conscious and critical of communication, as we have seen. The patients' responses also indicate that the non-Swedish physicians are more formal in their communication with patients than Swedish physicians are.

Most physicians from Northern Europe, the Baltic States and Eastern Europe and, to some extent, Germany report not changing communicative styles, while the opposite is true of the Mediterranean and Hungarian physicians and some of the German physicians.

It is not surprising that the North European respondents report not changing their communicative style; they may not see any differences in communication with the patients, as mentioned above. It is complicated to explain the responses from the physicians from the Baltic States and Eastern Europe as well as the Mediterranean and Hungarian physicians.

Differences in power distance and changed communicative style might be positive experiences for non-Swedish physicians, as many of them find that is it good to be informal and to have patients who are active and interested in the course of consultation. Consider the comment from IraD6:

Här [i Sverige] är det bra med förklaring. De behöver så här ... man berättar vad man gör. Det har jag lärt mig här. När man skall lyssna på hjärtat man berättar hela tiden: nu skall jag lyssna på lungorna nu ska jag få lite reflexer. När jag tänker nu det gjorde vi inte [i hemlandet] man bara drar upp skortan och börja undersöka utan att berätta för patienten. Jag tycker att det är mycket mänskligt så här att man berättar för patienten och varför man skriver den här medicinen. Jag hade inte svårt med det.	*Here [in Sweden] explaining is good. They need like this ... you inform what you're doing. I've learned that here. When you listen to the heart, you comment all the time: now I'll listen to your lungs, now I'll have some reflexes. When I think now, we didn't do that [in my home country] you simply pull up the shirt and start examining without informing the patient. I think it's much more human this way, that you inform the patient and why you prescribe this medicine. I had no difficulties with it.*

At the same time, some physicians find that the patients' informal style of talking to them and sometimes even questioning their decisions as a sign of a lack of respect, for example GerD12 (adapted from Berbyuk, 2005):

Här [i Sverige] är mannen [läkaren] som mer serverande. Doktor mmm man måste serva dem [patienterna]. Det var otänkbart att någon kunde ringa mig på telefon och fråga ... jag måste plocka i journalen och säga honom vad hon har på röntgenbilden vad som helst. Det var otänkbart. Här de ringer, man måste titta i journalen, man måste förklara prata med dem. Det var inte så. Här är man tjänare för dem, man måste serva.	*Here [in Sweden] one [the physician] is like more serving. Doctor, mmm, you have to serve them [the patients]. It was unthinkable that someone could call me on the phone and ask ... I have to search in the file and tell him what she has on the X-ray, whatever. That was unimaginable. Here they call, you have to look in the file, you have to explain, talk to them. It was not like that. Here you're a servant to them, you have to serve.*

4.3.2 "You never know what the patient thinks of you as a non-Swedish physician": the influence of conflict avoidance on the physician-patient relationship

As I have mentioned in earlier sections, the German physicians experience the most cultural understanding in their communication with Swedish patients. At the same time, most of them report experiencing differences in the ways patients talk to them in Sweden and in Germany. Compared to German patients, Swedes are seen by the German physicians as more satisfied, less oppressive, more patient, and ready to take more responsibility for the course of treatment, which is often appreciated: *svenskarna är mindre krävande, nöjdare, mer självansvarig* ('the Swedes are less demanding, more satisfied, more self-responsible'), *snälla patienter, mindre krav på doktorn jämfört med Tyskland* ('kind patients, less demands on the doctor compared to Germany'). As discussed, the responses obtained reflect the differences between Swedish and German cultures, such as a smaller power distance in Sweden than in Germany. The greater independence of Swedish patients compared to German ones may consequently be explained by the more hierarchical structure of German health care and an accepted paternalistic style in Germany, unlike in Sweden (Richter and Eisemann, 1999).

In addition to the differences in power distance, another factor influences the communication between German physicians and their Swedish patients in particular, and communication involving non-Swedish physicians in general: the Swedish conflict avoidance mentality. This attitude is manifested in the patients' unwillingness to, for example, express dissatisfaction to the physician openly, which is the opposite to the German way of expressing disagreement (Lewis, 2000; Hofstede, 2001).

Swedish conflict avoidance has both positive and negative sides. Feelings that "they talk behind your back" were mentioned by the non-Swedish physicians. Consider this comment from the interview with a Hungarian physician (HuD2):

Läkaren vet inte att patienten att patienten är onöjd med behandlingen bara få ett brev från myndigheten du blev anmäld.	*The physician doesn't know that the patient, that the patient is unsatisfied with the treatment, only get a letter from the authorities: you were reported.*

It is complicated for the physician to understand whether the patient is satisfied or not as the patient might not openly show dissatisfaction. This might create additional stress, anxiety and uncertainty for the non-Swedish physicians.

4.3.3 Problems with understanding in communication between non-Swedish physicians and Swedish patients

This subsection is devoted specifically to the issue of problems involving understanding in communication between the non-Swedish physicians and their Swedish patients, as comments on this topic are common in the interviews and the questionnaire responses.

Lack of understanding occurs when a receiver cannot connect incoming information with stored information, because (1) relevant information is missing and/or (2) a relevant strategy for connecting incoming with stored information is missing. *Misunderstanding* is the result of a receiver actually connecting incoming information with stored information, but where the resulting meaningful connection must be viewed as inadequate or incorrect (Allwood and Abelar, 1984). In health care communication, understanding between the patient and health care provider is essential. Researchers have analyzed this kind of understanding between participants from the same cultural background (e.g., Britten et al., 2000) and from different ones (e.g., Roberts et al., 2005). Both of the studies mentioned used recordings as a data collection method.

Britten et al. (2000) present 14 categories of misunderstandings in medical consultations, which arise (1) through a lack of exchange of relevant information in both directions, (2) as result of conflicting information or attributions, (3) when the patient failed to understand the doctor's diagnostic or treatment decision, or (4) from actions taken to preserve the doctor-patient relationship. It is worth pointing out here that in that study, no distinction is made between lack of understanding and misunderstanding. Roberts et al. (2005) analyze interactions between native-born physicians and patients with limited English and identify four main categories of patient "talk" which are related to their language competence and contribute to misunderstandings, namely (1) pronunciation and word stress; (2) intonation and speech delivery; (3) grammar, vocabulary and lack of contextual information; and (4) style of presentation. Both studies point to the fact that a number of problems often occur simultaneously, contributing to misunderstanding.

Below, I will first present the participants' views on the occurrence of problems with understanding in interactions, based on the data from the questionnaires. I will then analyze the transcriptions of the recorded medical interactions and interviews. Next, I will combine the participants' responses from the interviews and the questionnaires with the results of the analysis of data from the recordings of medical consultations.

In examining the questionnaires, I have focused specifically on the participants' reports of occurrences of misunderstanding in consultations (though it is not obvious that the respondents reported their experiences of misunderstanding only – see below). However, in the interviews, problems with understanding in general were the focus. The analysis of transcriptions also included the analysis of both lack of understanding and misunderstanding. It is important to mention here that, as Hinnenkamp (1999) points out, misunderstanding can be *overt* (i.e., the misunderstanding is immediately recognized in the interaction and is repaired) or *covert* (i.e., a more gradual recognition occurs in the interaction). (Unlike Allwood and Abelar, Hinnenkamp does not distinguish between lack of understanding and misunderstanding, though from the examples provided it can be seen that his focus is on "misunderstanding.") In addition, cases when an outside observer or the participants themselves are unaware of the misunderstanding (so-called *latent misunderstanding*) may

also be present in interactions. Therefore, cases of misunderstanding can be more or less complicated for the observer to distinguish. Taking this aspect into consideration, the analysis of transcriptions to detect problems with understanding was done independently by two project assistants (the author included), and later compared and discussed. Only the cases that both the transcribers agreed upon were selected.

4.3.3.1 Analysis of problems with understanding in medical consultations: data from the questionnaires

The responses obtained from the non-Swedish physicians and Swedish patients concerning occurrences of misunderstandings in interaction are presented in Table 36 (Q.25 and Q. 18 from the respective questionnaires).

Table 36: Non-Swedish physicians and Swedish patients: misunderstandings in communication (Q.25 and Q.18 respectively)

Non-Swedish physicians (Q.25)

Question	**Alternatives/number and % of respondents per alternative**				**# of resp.**
Did misunderstandings occur in conversation [with the Swedish patients] ?	Yes, often	Yes, sometimes	Seldom	No, never	
Non-Swedish physicians	3 4%	24 30%	51 63%	3 4%*	81
Male	2 4%	17 32%	33 62%	1 2%	53
Female	1 4%	7 25%	18 64%	2 7%	28
*The numbers do not add up to 100% because of rounding.					

Swedish patients (Q.18)

Question	**Alternatives/number and % of respondents per alternative**		**# of resp.**
Did misunderstandings occur in your conversation [with the non-Swedish physician] ?	Yes	No	
Swedish patients	15 19%	66 82%*	81
Male	4 9%	39 91%	43
Female	11 29%	27 71%	38
*The numbers do not add up to 100% because of rounding.			

Before discussing the responses, it is worth pointing out here that it is not really possible to know whether the respondents made a distinction between lack of understanding and misunderstanding; therefore, it is not clear whether they were reporting "misunderstanding" specifically or *any* problem(s) with understanding that occurred during consultation. Thus, it is reasonable to presume that reports of "misunderstanding" also include lack of understanding. That is why I mention "problems with understanding" in discussing the responses obtained.

The majority of the non-Swedish **physicians** reported that misunderstanding (or problems with understanding) occurred during consultation, though only "seldom" or "sometimes" (63% and 30%, respectively). On the contrary, few Swedish **patients** (19%) reported experiencing misunderstanding (problems with understanding) in their interactions with the non-Swedish physicians.

Concerning **gender**, the male non-Swedish physicians reported misunderstanding (problems with understanding) to be slightly more common than the female physicians, judging from their choosing "yes, sometimes" more often (32% of males, 25% of females). The opposite is true for the patients: 29% of the female Swedish patients reported occurrences of

misunderstanding (problems with understanding) in their interaction with non-Swedish physicians compared to 9% of male patients.

Overall, the following picture can be observed:

Table 37: Swedish patients: lack of understanding/misunderstanding in communication with non-Swedish physicians (same-sex and cross-sex medical encounters, Q.18)

Question	**Alternatives/number and % of respondents per alternative**		**# of resp.**
Did misunderstandings occur in your conversation [with the non-Swedish physician]?	Yes	No	
M phs–M pat	2 6%	32 94%	34
M phs–Fpat	5 17%	25 83%	30
F phs–F pat	5 63%	3 38%*	8
F phs–M pat	2 22%	7 78%	9
*The numbers do not add up to 100% because of rounding.			

The table shows that a considerably higher percentage of occurrences of misunderstanding (problems with understanding) is reported by patients in female-female medical consultations (F phs–F pat 63%) compared to other gender combinations. Male-male consultations are characterized by of the fewest reported misunderstandings (problems with understanding): M phs–M pat 6%.

No clear pattern can be observed in the answers of the Swedish patients with regard to age, gender and education. Concerning differences in experiencing of misunderstanding (problems with understanding) reported by the patients in relation to **age**, the younger female patients report more misunderstandings (problems with understanding) than the older ones, while the opposite is true of the male respondents. As for **education**, the fewest misunderstanding (problems with understanding) are reported by the patients with primary education, both male and female, and the male patients with postsecondary education, while the most problems with understanding are reported by both male and female patients with secondary education (see Appendix E).

The responses of the physicians with different cultural backgrounds are categorized in Table 38.

Table 38: Non-Swedish physicians: misunderstandings in communication with Swedish patients (cultural groups, Q.25)

Question	**Alternatives/number and % of respondents per alternative**				**# of resp.**
Did misunderstandings occur in conversation?	Yes, often	Yes, sometimes	Seldom	No, never	
Germany	2 7%	8 29%	18 64%	0 0%	28
Hungary	0 0%	0 0%	9 90%	1 10%	10
Northern Europe	0 0%	0 0%	7 100%	0 0%	7
Mediterranean	0 0%	3 38%	4 50%	1 12%	8
Former Yugoslavia	0 0%	0 0%	4 100%	0 0%	4
Baltic States and Eastern Europe	0 0%	1 11%	8 89%	0 0%	9
Middle East	1 10%	9 90%	0 0%	0 0%	10 100%
Mixed	0 0%	2 50%	2 50%	0 0%	4 100%

Due to the low number of respondents, it is difficult to draw any definite conclusions. However, it can be seen that the physicians from the Middle East report more misunderstandings (problems with understanding) than the respondents of other groups, choosing the alternatives "yes, often" (10%) and "yes, sometimes" (90%); they are followed by the German physicians and the physicians in the Mixed group.

Few responses were obtained concerning the reasons for problems with understanding. Finding the right word, pronunciation problems, failure to see whether the patient understands what is being said, problems understanding detailed medical explanations from the patients, etc., were mentioned.

To summarize, the responses indicate the following:

The participants report occurrences of misunderstanding (problems with understanding) in interactions. The physicians consider them to occur more frequently than the Swedish patients. The male non-Swedish physicians report more misunderstandings (problems with understanding) than the females, while the opposite is true of the Swedish patients, especially in communication with the female physicians.

One should bear in mind that the occurrence of problems with understanding depends on many factors and one might question whether the respondents' evaluation is reliable evidence. One might also contemplate possible explanations for the obtained results, bearing in mind that the questions were formulated slightly differently; the non-Swedish physicians were asked about their experiences of misunderstanding (problems with understanding) in general (all patients), while the patients were asked about their experience of misunderstanding (problems with understanding) in interaction with a specific non-Swedish physician. As a result, the non-Swedish physicians described a *general* picture, which might be more negative compared to the reports of the Swedish patients, who have to describe a *specific* occurrence of consultation, which might be memorable because it was extremely

positive or extremely negative. At the same time, one might also suppose that the non-native speakers' more negative picture might be due to the uncertainty they experienced in communicating in the interlocutor's native language. In addition, the combination of being a non-native speaker and a physician – the participant who is responsible for communication in general and for being understood in particular – might result in the non-Swedish physicians reporting misunderstandings (problems with understanding) more than the patients. I cannot formulate a good explanation of the gender differences in reporting of misunderstandings (problems with understanding). Perhaps females find it harder to believe that they can be misunderstood. The occurrence of misunderstandings (problems with understanding) and how they are reported might also depend upon other factors than gender. However, the female patients' responses follow the same pattern as above: they are more critical of the female physicians than the male ones.

The respondents with primary education report the fewest misunderstandings (problems with understanding), while those with secondary education report the most.

This result might indicate the same tendency as the responses to the previous questions: better-educated patients have a more critical attitude and less-educated patients are less critical. However, the data are inadequate to draw any definite conclusions. Similarly, it is difficult to reach any definite conclusions concerning why the physicians from the Middle East report more misunderstandings (problems with understanding) than the respondents in the other groups.

In the next section, the analysis of problems with understanding that are observed in the recordings of medical consultations between non-Swedish physicians and their Swedish patients and in the interviews is described.

4.3.3.2 Analysis of problems with understanding in medical consultations: data from the interviews and recordings of medical consultations

In total, 41 occurrences of problems with understanding were found in the transcriptions of the recorded interactions. Thirty-one of them are classified as cases of lack of understanding and 10 as cases of misunderstanding.

The participants' **lack of acquaintance with vocabulary** (i.e., one participant [physician or patient] uses a word or form the other participant does not know) is one of the reasons for lack of understanding/misunderstanding in intercultural medical encounters.

As the non-Swedish physicians mentioned in the interviews, they sometimes used medical terms instead of Swedish terms, as they did not know the Swedish equivalents and were unable to explain what they meant in Swedish. Consider the comment from the Polish female physician (PolD17) which illustrates this (adapted from Berbyuk, 2005):

Kanske i början var det mycket svårare på grund av språket. Den som är verkligen svårt är att känna till vanligt familjär språk som patienten använder hemma. Till exempel, vi brukar använder ordet "kolon" istället av "tjocktarm", men inte alla patienter förstår. Så de vanliga vanliga ord som man bör använda med patienten. Vi förstår patienten bra, men patienten kan inte förstå oss.	*Maybe at first it was much more difficult because of the language. What's really difficult is to know ordinary familiar language that the patient uses at home. For example, we usually use the word "colon" instead of "large intestine," but not all patients understand. So these ordinary, ordinary words that you should use with the patient. We understand the patient well, but the patient can't understand us.*

Using Latin terms with medical personnel is fine, but not with patients, according to the non-Swedish physicians. However, it is often complicated to explain to the patient what is meant (IraqD14):

"multicystisk förändring i äggstockar" ... förändring och äggstockar kan patienten förstå, men inte multicystisk. Ska läkaren som utomländska hitta ord på vanligt sprak? vad betyder "multicystisk"? många påsar som hanger tillsammans det är inte så lätt att förklara.	*"multicystic alteration in ovaries" ... alteration and ovaries the patient can understand, but not multicystic. Should the physician as a foreigner find the words in ordinary language? What does "multicystic" mean? Many bags that hang together – it's not that easy to explain.*

Consider the example below, an excerpt from the recorded interaction between a German male physician (GerD12) and a male patient who had undergone back surgery, which illustrates the above point (adapted from Allwood and Berbyuk, 2006):

Example 5. "Spoldiroristes" (GerD12)

Physician asking the patient about his problems

Speaker	Transcription	Translation into English
$D:	e: // e / (...) trombos oj oj oj oj oj // ja men varför <1 >1 (fusion vad var det) ostabilt 2 < 3< **spoldiroristes** >3) >2 //	*er // er / (...) thrombosis oh oh oh oh oh // yes but why <1 >1(fusion what was it) unstable 2 < 3 < (**spoldiroristes**) >3 >2 //*
@ < 1 gaze stop: looking down in the papers and reading >1 @ < 2 hand movement: waving illustrating instability >2 @ < 3 SO: spondylolistes/spondylolisthesis >3[17]		
$P:	<1 ja hänger inte me >1 <2 // >2	*<1 I don't follow >1 <2 // >2*
@ <1 head movement: shake >1 @ <2 laughter >2		
$D:	<1 gör du <2 inte >2 >1	*<1 you <2 don't >2 >1*
@ <1 laughter: P >1 @ <2 gaze: looking in the papers >2		

The physician's use of medical term for the disease (*spondylolisthesis*) causes a lack of understanding on the patient's side. In addition, the physician's poor pronunciation might influence the patient's understanding as well. The patient explicitly expresses his lack of understanding (*ja hänger inte me* ['I don't follow']). Deictic and iconic gestures help to solve the problem as the interaction proceeds (adapted from Allwood and Berbyuk, 2006):

Example 6. "Spoldiroristes" (GerD12) (cont.)

Speaker	Transcription	Translation into English
$D:	< du har opererat här >	*< you had surgery here >*
@ < hand gesture: right hand on back >		
$P:	< opererat ryggen ja >	*< back surgery yeah >*
@ < hand gesture: right hand on back >		
$D:	ja	*yeah*
$P:	fjärde femte	*fourth fifth*
$D:	varför //	*why //*
$P:	ja [1 de var väl]1 ostabilt	*well [1 I suppose it was]1 unstable*
$D:	[1 va var de]1	*[1 what was it]1*
$D:	< ostabilt >	*< unstable >*
@ < head movement: nod >		
$P:	ja	*yeah*
$D:	< okej >	*< okay >*
@ < head movement: nod >		
$P:	de e ju stelopererat [2 (...)]2 ja	*why the joints are fused [2 (...)]2 yeah*
$D:	[2 < det menar jag >]2	*[2 < that's what I mean >]2*
@ < head movement: nod >		

17. Spondylolisthesis is a condition in which one vertebra slips on another, causing low back pain (Dawson, no date).

$D:	ostabilt <1 det <2 slider >2 så // främre >1 // **de [3 heter <3 (spoldirolistes) >3]3**	*unstable <1 it <2 slides >2 like this // front >1 //* ***it's [3 called <3 (spoldirolistes) >3]3***
@ <1 hand gesture: right hand in the air making a sliding gesture >1 @ <2 SO: glider/slides >2 @ <3 SO: spondylolistes/spondylolisthesis, hand gesture: pointing at P with right hand >3		
$P:	[3 < m >]3	*[3 < m >]3*
@ < head movement: nod >		
$P:	okej < // >	*okay < // >*
@ <laughter: D >, < facial gesture: P smiles >		

Both physician and patient attempt to handle the lack of understanding. Hand gestures are used: the participants put their hands on their backs more or less at the same time. The physician shows the instability of the spine by performing a sliding gesture, while the patient nods, indicating his active listening. Other examples of problems with understanding on the patients' side are due to the non-Swedish physicians' use of words from their native languages or English; for example, the same German physician uses the word *Pritsche*[18] in giving instructions to the patient, which the patient does not understand.

I would also like to draw the reader's attention to the presence of laughter in the above-mentioned excerpts (examples 5 and 6). Ragan (2000) points to the role of humor and laughter in medical interactions as a "tool" to create a better atmosphere during the consultation, to induce an affinity between physician and patient and to mitigate psychological stress, which might be the case in the examples above. The participants use laughter to lighten the mood of consultations that are obviously difficult from the point of view of communication and soften the situation when both physician and patient are stressed about the interaction and their understanding problems. Joint laughter is a way to ease the pressure; it is also a face-saving strategy.

The Swedish patients also use words the physicians do not understand, primarily colloquial forms. This often happens during small talk in medical consultations, that is, communication concerning issues that are not related or not directly related to the goals of the consultation. The non-Swedish physicians report experiencing problems engaging in small talk with Swedish patients, which is unfortunate as chat is often beneficial in making good contact with the patient (Ragan, 2000). Luthy et al. (2005) analyze how patients define "good" and "bad" doctors; they point out that, apart from appreciating professional competence, the patients consider a good doctor as one who is able to make contact with the patient and provide emotional support (this is also proved by the responses to questions about the physician's obligations, presented in 4.2.1). As the interviews show, the informal part of the consultation can be more complicated for the non-Swedish physicians than the medical portion, as it requires a higher level of language, as well as cultural competence. The female physician from the former Yugoslavia (YugD19) comments on this:

18. Pritsche (German) 'plank bed'.

Mitt ordförråd fortfarande är inte så stor det är begränsat ... här i medicin miljö jag kan lite mer men om vi pratar om fisk ... saknar många ord.

My vocabulary still isn't very large it's limited ... here in medical environment I know a little more but if we talk about fish ... lack many words.

The physician from Iran (IraD6) also talks about problems initiating informal talk and joking (adapted from Berbyuk, 2005):

I hemlandet kunde jag skämta med patienten lite grann, och hon eller han blev lite glad och jag också, vi skrattade å sånt ... jag kunde skämta lite grann. Kanske jag kan inte nu ... på samma sätt. Jag har lärt mig lite grann såna kneper när jag leker lite grand med ord å så ... att patienten ler lite grand det är lite grann mildare stämningen. De är spända när de kommer till läkare, de är oroliga, man kan bygga det här förhållande att det inte är så allvarligt. Jag var jättebra på det här i hemlandet, jag kunde göra det fort i början att hälsa någonting om utseendet eller sånt. Det är svårare här. Jag har kommit in lite grand, men det räcker inte om man jämför med [i hemlandet] jag har bott här i Sverige 13 snart 14 år jag kan som en 14 åring kan man säga och det är fortfarande barnsligt språk.

Back home, I could joke with the patient a little, and he or she was glad and me too, we laughed and things like that ... I could joke a little. Maybe I can't now ... in the same way. I have learned a few such tricks when I play a little with words and so ... that the patient laughs a little, it's a bit milder atmosphere. They are tense when they come to see the doctor, they are anxious, you can create this relationship that it's not so serious. I was really good at this back home, I could do it quickly in the beginning to greet and say something about appearance or so. It's more difficult here. I've managed a little, but it's not enough compared to [back home], I've lived here in Sweden for 13, soon 14, years, I master it as a 14-year-old, you could say, and it's still childish language.

In the example below, the same Iranian physician who commented on informal talk above (IraD6) is observed having problems understanding her patient's joke (adapted from Berbyuk, 2005):

Example 7. "Bend plastic" (IraD6)

Physician and patient talking about the patient's occupation

Speaker	Transcription	Translation into English
$D:	jobbar du eller	*do you work or*
$P:	a	*yeah*
$D:	va jobbar du me	*what do you do*
$P:	**ja böjer plast** <1> <2 // >2 nej vi håller på å tillverkar mobiltelefonhållare å sånt här	***I bend plastic*** *<1> <2 // >2 no we make brackets for mobile phones and stuff like that*
@ <1 laugh >1 @ <2 body movement: D leans forward and doesn't seem to understand what P means >2		

In answering the physician's question about his job, the patient attempts to joke (*ja böjer plast* ['I bend plastic']). However, he realizes that she does not seem to understand (lack of understanding) what he means (see comments on non-verbal behavior, i.e., doctor leaning forward) and immediately explains what he had said.

Incorrect pronunciation by the non-Swedish physicians and elderly patients' hearing problems represent an unfavorable combination for understanding. In the example below, the lack of understanding occurs between a Hungarian physician and his elderly female patient:

Example 8. "Become better" (HuD3)

Physician and patient talking about results of surgery

Speaker	Transcription	Translation into English
$D:	**< okej > / ö: / har du blivit mycke bättre e efter operation / va tycker du**	***< okay > / er / have you improved after er surgery / what do you think***
@ < head movement: nods >		
$P:	**< hm >**	***< hm >***
@ < body movement: leans towards D, to hear better >		
$D:	**har < dy > blivit mycke BÄTTRE efter operation**	***have < you > become much BETTER after surgery***
@ < SO: du/you >		
$P:	< med de här >	*< with this >*
@ < hand gesture: pointing with right hand on stomach >		
$P:	ja	*yeah*

The elderly patient has problems understanding the physician's question, as can be observed from her non-verbal behavior. The physician repeats the question and, with the help of emphasis and gestures, the lack of understanding is resolved.

Problems with grammar are also observed to cause problems with understanding. In the interviews, the physicians often comment on problems in formulating the messages, as HuD3 does in this excerpt:

> Jag kände att jag har en stor vetenskap kunskap bakom i huvudet, men det kommer inte fram. Jag vill gärna säga jag vill gärna kommunicera, men kan inte formulera.
>
> *I felt that I have much science knowledge behind in my head, but it doesn't come forward. I would like to say I would like to communicate but cannot formulate.*

Non-Swedish physicians often use the patient's file as a helpful tool in their interactions with the Swedish patients. Reading questions from the file and using them in consultations is an easy way to get information from the patient. However, in some cases, reformulation of the question is necessary for the patient to understand what is meant. Consider the example below:

Example 9. "Latest examination" (GerD12)

Physician inquiring about the patient's latest examination

Speaker	Transcription	Translation into English
$D:	**ö: senaste undersökning datum (...)**	***er latest examination date (...)***
$P:	**va sa du**	***what did you say***
$D:	**senaste undersökning / när har du varit [(...)]**	***lates examination / when you have been [(...)]***
$P:	[ja ungefär] två år sen	*[yeah about] two years ago*

Here, an unclear formulation results in problems with understanding. The physician has to

repeat and reformulate his message for the patient to understand what is meant.

The example below is an another illustration of problems due to the physician's incorrect formulation:

Example 10. "We misunderstand each other" (HuD2)

Physician inquiring about when the surgery took place

Speaker	**Transcription**	**Translation into English**
$D:	**< e: när kommer du tillbaka när blir > du opereras e**	***< er when will you come back when will > you have surgery er***
@< gaze: looks down in the papers >		
$P:	<1 >1 <2 ja blev opererad i maj väl >2 //	*< 1>1 <2 I had surgery in may I think >2 //*
@ <1 body movement start: P leans forward >1 @ <2 gaze: looking straight ahead >2		
$D:	ö nej < // >	*er no < // >*
@ < gaze: D looks at A (the patient's daughter) >		
$P:	jo förra < år > jo förra året	*well yeah last < ye+ > yeah last year*
@ < cutoff: året/year >		
$A:	m	*m*
$D:	< ja >	*< yeah >*
@ < head movement: nods >		
$P:	ja	*yeah*
$D:	**men <1 vi missförstår >1 <2 varandra >2 [1 <3 ja frågade / när]1 var du >3 eller när när har du fått / narkos sista [2 gången]2**	***but < 1 we misunderstand >1 <2 each other >2 [1 <3 I asked / when]1 were you >3 or when when did you have / anesthetic last [2 time] 2***
@ <1 hand gesture: with right hand >1 @ <2 head movement: nods >2 @ <3 hand gesture: with right hand >3		
$P:	[1 ja jo / ja]1	*[1 yeah well / yeah] 1*
$P:	[2 ja]2 / nu va de att ja har varit här två gånger	*[2 yeah] 2 / actually I have been here twice*

The physician realizes from the patient's answer that she misunderstood the question. She draws attention to it (*men vi missförstår varandra* ['but we misunderstand each other']) and reformulates her message so the patient will understand what she meant.

Few occurrences of lack of understanding/misunderstanding found in the data are coded as "**other-content**." As Allwood and Abelar (1984) mention, it is complicated to say what could potentially be misunderstood with regard to content and it is difficult to classify this type of understanding problem. *All* the examples mentioned above involve problems with understanding of content, though the reasons are not the participants' lack of knowledge of what is being discussed, but problems resulting from how it is said, that is, vocabulary, grammar, pronunciation, etc. In Allwood and Abelar's study, the cases when misunderstandings occurred were treated as related to problems understanding the content when the interactants had different background information about such domains as food, clothing, homes, health, activity, attitudes and values. At the same time, the authors emphasize that all the misunderstandings they noted also concern attitudes and values, but

within different spheres of life. Similarly, in the data used in my study, few occurrences of lack of understanding/misunderstanding were distinguished when no other factors (such as language problems) existed and only the physicians' and patients' background knowledge was the cause of problems with understanding. In the example below, the lack of understanding occurs on the patient's side, when the Hungarian physician and her Swedish patient are talking about the patient taking too many sleeping pills:

Example 11. "Bears in winter" (HuD2)

The physician warns the patient about sleeping pills

Speaker	Transcription	Translation into English
$D:	de <1 e för mycket för >1 sömntabletter [1 <2 tre gånger >2]1	*that's <1 too much for >1 sleeping pills [1 <2 three times >2]1*
@ <1 head movement: shake >1 @ <2 laughing >2		
$P:	[1 < de e mycke >]1 ja tar inte en [2 var fjortonde da]2 en gång	*[1 <that's much >]1 I don't even take one [2 every two weeks]2*
@ < laughing >		
$D:	**[2 < ska sova som björnar >]2**	***[2 < will sleep as bears >]2***
@ < laughing >		
$D:	**< på vintern nä >**	***< in winter no >***
@ < laughing >		
$P:	som sagt var / ja tar inte en var fjortonde dag	*as I said / I don't even take one every two weeks*

The physician comments that the patient takes too many sleeping pills and jokingly says that she will sleep like a bear, a joke which the patient apparently does not understand.

To summarize, problems with understanding in intercultural medical encounters are observed to occur due to problems with vocabulary (physicians' and patients' lack of knowledge of the words used), phonology and hearing problems, grammar (problems with syntax as well as use of incorrect word forms; see Allwood and Berbyuk, 2006, for examples) and contents.

In Table 39, an overview of the number of occurrences of each type of problem observed in the data is provided. Problems with understanding arise due to problems with vocabulary, phonology and hearing deficits, grammar and lack of shared background knowledge. However, it is worth mentioning here that in some cases it is complicated to attribute the understanding problem to a single factor. In the data, pronunciation is an additional factor from the patients' perspective, when the physician is a non-native speaker. In addition, if patients speak fast and, though this is not represented in the data, use dialect, these are additional reasons for considering pronunciation as a contributing factor to problems with understanding. Therefore, in Table 39 I mention pronunciation as a possible cause of such problems in parentheses.

Table 39: Types and frequencies of problems with understanding

Causes of problems with understanding/ participant who experiences them	# of occurrences	
	Lack of understanding	Misunderstanding
Vocabulary (and pronunciation)		
Physician	3	0
Patient	3	3
Phonology, hearing problems		
Physician	1	0
Patient	11	0
Grammar (and pronunciation)		
Physician	0	0
Patient	8	3
Other-content (and pronunciation)		
Physician	0	2
Patient	5	2
Total lack of understanding physicians: 4 **Total misunderstanding physicians: 2**		
Total lack of understanding patients: 27 **Total misunderstanding patients: 8**		
Total:	**41**	

One should bear in mind that the participants' own evaluation of their understanding and the observer's analysis differ, as problems with understanding can be covert or overt to a greater or lesser extent. As we can see, the majority of problems with understanding, both lack of understanding and misunderstanding, were experienced by the patents. The reason is that the physicians' problems with grammar and pronunciation caused the majority of understanding problems in the data. The physicians were observed to experience few problems with understanding.

4.3.4 Word-finding problems in communication between non-Swedish physicians and Swedish patients

The non-Swedish physicians claim that word-finding problems are their main language problem, and that they often occur in stressful situations, for example, *Vid akut nödsituation kan min kommunikation vara sämre, falla tillbaka till tyska eller sakna ord* ('In acute emergency situation, my communication may be worse, fall back to German or lack words'). As I have already mentioned above, one can be too brief, and this is a negative factor, especially when a physician has to talk about sensitive issues. Consider this excerpt from the interview with a Hungarian physician (HuD2):

IVA det är jättekänsligt område. Du pratar med anhöriga och beskriva händelser. Nu känner jag att jag inte har tillräckligt med språk att förklara eller vilka ord man kan använda.	*Intensive care is a very sensitive area. You talk to relatives and describe events. Now I feel I don't have enough language to explain or what words one may use.*

A German physician comments on the same issue (GerD13):

vill man ju ibland uttrycka sig lite försiktigare, lite känsligare, och det är ibland lite svårt.	*Sometimes you just wish to express yourself a bit more carefully, more sensitively, and that's a little difficult sometimes.*

In Allwood and Berbyuk (2006), a detailed analysis of word-finding problems and solutions to these problems is presented. The reader is referred to that article for a detailed analysis and examples. Below, I present only a brief overview of the ways of handling word-finding problems that have been observed in the data (Figure 3 followed by Table 40, which presents the frequencies of different ways of handling word-finding problems [adapted from Allwood and Berbyuk, 2006]):

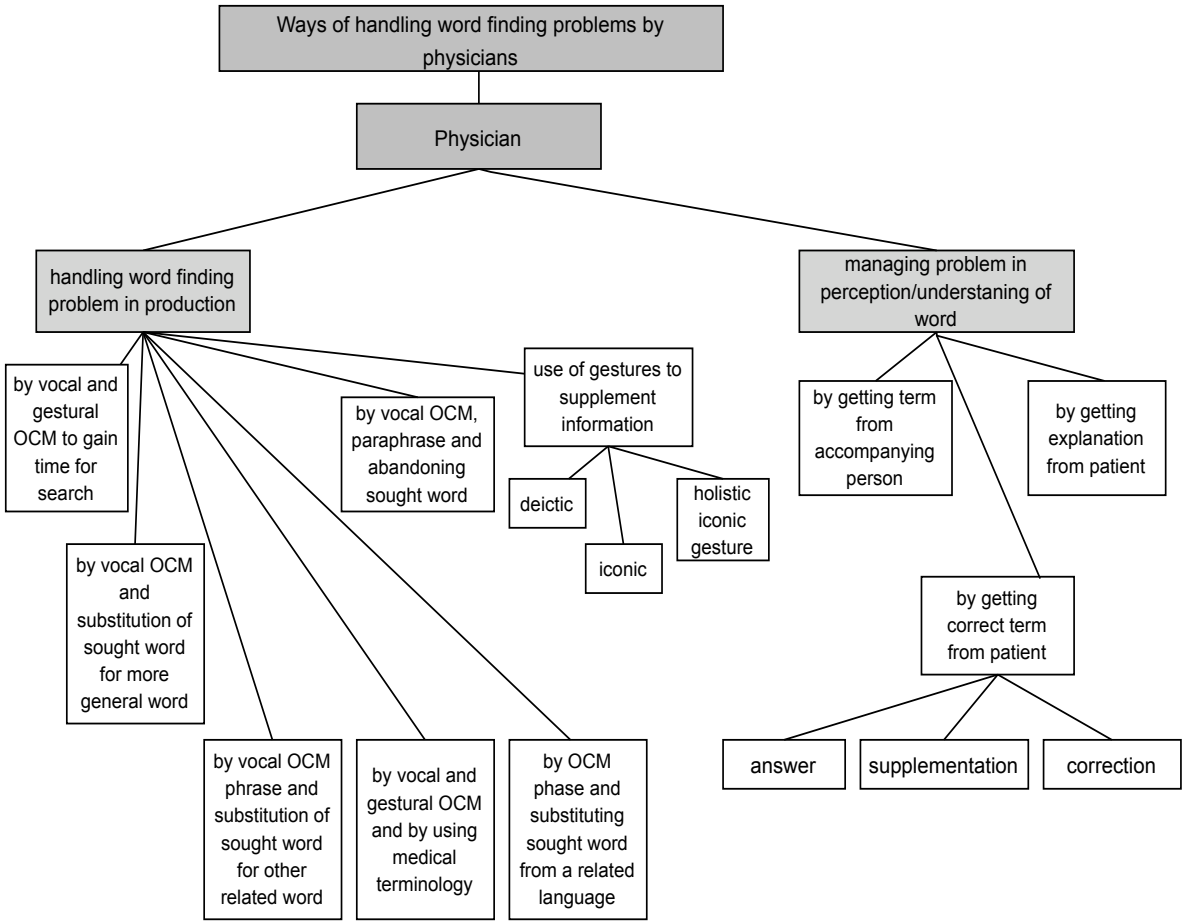

Figure 3: Non-Swedish physicians' ways of handling word-finding problems

Table 40: Frequency of use of different ways of handling word-finding problems

#	Ways of handling word-finding problems	# of occurrences
The physician handles word-finding problem in production		
1.	by vocal and gestural OCM	23
2.	by vocal OCM and substitution of sought word by more general word	2
3.	by vocal OCM phrase and substitution of sought word by related word	2
4.	by vocal OCM, paraphrase and abandoning sought word	8
5.	by OCM phrase and by substituting sought word from a related language	5
6.	by vocal and gestural OCM and by using medical terminology	3
7.	use of gestures to supplement information	
a	*deictic*	*4*
b	*particular iconic*	*8*
c	*holistic iconic*	*1*
The physician handles problem in perception/understanding of word		
8.	by getting explanation from patient	1
9.	by getting correct term from patient	
a	*answer*	*2*
b	*correction*	*2*
c	*supplementation*	*2*
10.	by getting term from accompanying person	1
Total:		**64**

In the majority of cases, the non-Swedish physicians solve their word-finding problems themselves, primarily by using vocal and gestural own communication management (OCM)[19] (23 occurrences) and by using supplementing gestures (13 occurrences) and vocal OCM and paraphrases. In a few cases, the physicians abandoned the search for the word (8 occurrences). Other strategies (use of an OCM phrase, word from a related language, use of vocal OCM and substitution of the sought word by a more general or a related word) were less common. The physicians were also observed using medical terminology in case of word-finding problems (3 occurrences).

The above data show that the physicians rarely get help from their patients and patients' relatives with word-finding problems: only in eight occurrences out of 64 did the patient or the patient's relative become directly involved and help the physician. In section 4.4, I will present the participants' views on patients functioning as informal teachers. In the next subsection, I will focus on another issue mentioned by the participants, namely taboo topics in interactions.

19. OCM stands for "processes that speakers use to regulate their own contributions to communicative interaction" (Allwood, 1993a). OCM comprises hesitation sounds, lengthening of continuants, self-interruption, self-repetition, etc.

4.3.5 Taboo topics in interactions between non-Swedish physicians and Swedish patients

Some conversational topics are taboo (i.e., proscribed by society as improper or unacceptable) in one culture but not in another, which means that interactants consciously avoid raising them in the course of interaction. Consequently, in medical consultation, certain issues might be difficult to discuss with the patients from a certain cultural background. For example, American physicians interacting with Russian immigrants point to the cultural taboo against disclosing a cancer diagnosis or even saying the word "cancer" ("the C word"), as the patient may see this as a "death sentence" (Dohan and Levintova, 2007, p. 302). Other examples that can be mentioned here are Taiwanese adolescents' views of the menstrual cycle (Cheng et al., 2007) and delivering bad news to terminally ill patients or their families in China (Tse et al., 2003), etc.

A physician who is a newcomer to the patient's language and culture should be aware of this issue. In Swedish culture, for example, a patient's alcohol problems are a sensitive topic, as discussed in the reports of The Swedish Risk Drinking Project (Pettersson, 2006) and even by the respondents of my own project, the non-Swedish physicians and Swedish medical personnel.

The Swedish personnel were asked an open-ended question in the questionnaire about what topics might be taboo in medical consultations (Q.11); the non-Swedish physicians were asked whether a communication problem had ever occurred due to their raising issues that are taboo in Sweden but not in their home countries (Q.32, a yes-no question). Both groups were also asked to comment on the topic.

Few non-Swedish physicians answered yes to the question concerning the taboo topics; those who commented mentioned their caution primarily in talking about alcohol. The Swedish personnel, in addition to mentioning alcohol, also mentioned political views, drugs, smoking, income, cancer, sexual issues, family problems, and abuse.

An interesting excerpt from the interaction between a Hungarian physician and his elderly Swedish patient illustrates the sensitivity of talking about alcohol habits (adapted from Allwood and Berbyuk, 2006):

Example 12. "Sober" (HuD3)

Speaker	**Transcription**	**Translation into English**
$D:	**e <1 >1 förlåt mej men ja måste e fråga dej e om e två saker till / e brukar du <2 dricka alkohol eller inte >2**	***er < 1 >1 I pardon me but I must er ask you er about two more things / er do you usually <2 drink alcohol or not >2***
@ <1 inhalation sound >1 @ <2 head movement: nods >2		
$P:	ja använder inte alkohol	*I don't use alcohol*
$D:	**okej < e du nykter >**	***okay < are you sober >***
@ < head movement: nod >		
$P:	< HM >	*< HM >*
@ < body movement: leans towards D to hear better >		
$D:	**< NYKTER >**	***< SOBER >***
@ < head movement: nods >		

$C:	< nykterist ja >	*< teetotaler yeah >*
@ < gaze: P looking at C (the patient's daughter) >		
$D:	[1 nykterist ja]1 nykterist [2 okej]2 < ja >	*[1 teetotaler yeah]1 teetotaler [2 okay]2 < yeah >*
@ < head movement: nods >		
$P:	[1 nykterist]1	*[1 teetotaler]1*
$P:	[2 ö:]2	*[2 er]2*
$P:	sen nittonhundrafemtitre	*since nineteen fifty-three*
$D:	< okej >	*< okay >*
@ < head movement: nods >		
$P:	har ja inte använt sprit	*I haven't used alcohol*
$D:	oj	*wow*
$P:	annat än i medicinskt bruk	*in other than medical purposes*
$D:	**< a visst visst visst >**	***< yeah sure sure sure >***
@ < head movement: nods >		

This example illustrates the physician's careful way of asking his question about alcohol consumption, introducing it with "pardon me," which shows his awareness of the sensitivity of the topic. Unfortunately, he uses the wrong form of the word (*nykter* ['sober'] instead of *nykterist* ['teetotaler']). When the lack of understanding (and obvious bewilderment of the patient, who probably thinks that the physician is asking whether he is sober at the time of consultation) becomes apparent, the physician gets upset about it. This can be seen in his feedback, *a visst visst visst* ('yeah sure sure sure') as well as supportive head nodding, after the patient's relative helps with the word and the patient tells his narrative about being a teetotaler.

The excerpt below also exemplifies a female Iranian physician's stress when talking about alcohol problems:

Example 13. "What do you mean by 'bad'?" (IraD6)

History taking. Talking about alcohol

Speaker	Transcription	Translation into English
$D:	nej // hur e de me < alkoholvaner >	*no // what about < alcohol habits >*
@ < SO: alkoholvanor/alcohol habits >		
$P:	**de e dålit**	***it's bad***
$D:	**< de e dålit dålit va menar du me dålit >**	***< it's bad bad what do you mean by bad >***
@ < laughter: P >		
$P:	a de e inte mycke	*well it's not much*
$D:	< ja de e bra // de e inte dålit > okej // då man kontrolleras (...)	*< well that's good // that's isn't bad > okay // then one is controlled (...)*
@ < laughter: D, P >		

When the physician asks about alcohol consumption, the patient jokingly answers that it is bad. The physician apparently becomes stressed, not understanding that the patient is joking. This example illustrates both the physician's tension in talking about a sensitive issue and the above-mentioned problems with understanding small talk and joking in interactions.

4.4 Swedish patients and personnel as informal teachers: help with language problems during consultations

We also wondered whether Swedish patients, accompanying persons and health care personnel would help to solve the language problems experienced by the non-Swedish physicians. However, as can be seen from section 4.3.4, not many occurrences of patients' helping with word-finding problems were found in the data.

Both the non-Swedish physicians and the Swedish patients were asked about this issue in their questionnaires and the interviews. The participants' responses are presented in Table 41.

Table 41: Non-Swedish physicians and Swedish patients: help with language problems (Q.26 and Q.17a respectively)

Non-Swedish physicians (Q. 26)

Question	**Alternatives/number and % of respondents per alternative**			**# of resp.**
Did you get help from Swedish patients in case of language problems?	Yes	No	Sometimes	
Non-Swedish physicians	25 33%	11 14%	41 53%	77
Male	17 33%	4 8%	30 59%	51
Female	8 31%	6 23%	12 46%	26

Swedish patients (Q. 17a)

Question	**Alternatives/number and % of respondents per alternative**		**# of resp.**
Did you help the non-Swedish physician with language problems?	Yes	No	
Swedish patients	21 27%	57 73%	78
Male	8 19%	34 81%	42
Female	13 36%	23 64%	36

The table shows that the majority of the non-Swedish **physicians** report getting help with language problems from their Swedish patients at least some of the time (the alternatives "yes" and "sometimes" account for 86% of the responses). The female respondents report getting help from their patients less than the males ("no" response: males 8%, females 23%). Turning to the **patients**, the majority of the respondents (73%) report not helping non-Swedish physicians with language problems. The female patients consider themselves to help more than the male patients (females 36%, males 19%).

As for the patients' **age** and **education** (for the data, see Appendix E), the older male patients report helping more than the younger ones while no differences can be observed for the female patients. Males with postsecondary education and females with secondary education help more than other educational groups. Regarding the different cultural groups, only the physicians from the Nordic countries report not getting any language help from the patients, which may be related to their language competence. Otherwise, no clear tendencies can be observed.

The patients' responses concerning language help in same-sex versus cross-sex cultural encounters are presented in Table 42.

Table 42: Swedish patients: help with language problems for non-Swedish physicians (same-sex and cross-sex medical encounters, Q.17a)

Question	**Alternatives/number and % of respondents per alternative**		**# of encounters**
Did you help the non-Swedish physician with language problems?	Yes	No	
M phs–M pat	5 15%	29 85%	34
M phs–Fpat	11 38%	18 62%	29
F phs–F pat	2 29%	5 71%	7
F phs–M pat	3 38%	5 62%	8

The table shows that male-male consultations are characterized by the least help for the physicians as reported by the patients (15%), followed by female-female consultations (29%). Thus, cross-sex medical encounters are characterized by more help from the patient than same-sex ones.

To summarize, the following picture emerges:

The majority of the non-Swedish physicians report getting help with language from their Swedish patients. However, the majority of the Swedish patents report not providing language help to their physicians.

I presume the reason the non-Swedish physicians report getting help more than the patients report providing it might be the greater self-awareness of the physicians; we saw the same situation with misunderstandings. Another reason may be that the physicians are describing a general picture while the patients focus on a single consultation.

The female physicians report getting less language help, while the female patients report helping more than the males. The male-male encounters are characterized by the least help from patients.

The fact that the female physicians get less help than the males might explain their lower satisfaction level compared to their male colleagues. The female patients' greater helpfulness with language problems (according to their own reports) might reflect their being more "immediate" in their non-verbal behavior (e.g., they smile, nod, and gaze more, are more physically expressive, and approach others more closely) (see Chapter 2), which makes them more sensitive to language problems. At the same time, the fact that patients do not help more often might be the result of activity influence (i.e., the physician's dominant role might keep the patient from correcting the physician's language).

The fact that male-male encounters are characterized by the least help might reflect certain male characteristics, which are opposite to the female ones mentioned above. The involvement in the interaction of a female (physician or patient) results in increased collaboration and help being reported by the patients. However, the female patients tend to help the female physicians less than the male ones. I cannot formulate a good explanation for this observation.

There is a tendency for the more educated patients to help their physicians more with language than the patients with a lower educational level.

This may be due to the influence of education, as discussed above.

The patients were also asked to specify what kind of help they had provided to the physicians (Q.17b). All the alternatives were chosen at least once: assistance with finding the right word, helping the physician to see whether the patient understands and helping to provide a more detailed medical description.

As I already mentioned above, the reader is referred to the article by Allwood and Berbyuk (2006) for a comprehensive analysis and examples of the patients' linguistic assistance to the non-Swedish physicians. The Swedish patients may provide a word the physician cannot retrieve, explain a word the physician does not understand, provide a word after an explicit question from the physician, or correct the physician if the word used is incorrect. Below, I present an example in which the physician uses an incorrect word and is corrected by the patient.

The Iranian ophthalmologist (IraD9) and his Swedish male patient are talking about the patient's eyesight after an operation. In response to the physician's question about his eyesight, the patient reports that the left eye functions better for short distance and the right for long distance:

Example 14. "Combine or complement" (IraD9)

Speaker	**Transcription**	**Translation into English**
$P:	<1 de här funkar på >1 nära avstånd bäst [inte på] långt avstånd <2 de funkar på långt avstånd <3 bäst >3 men inte på nära >2 / <4 så att dom >4	*<1 this functions >1 best at short distance [not at] long distance <2 this functions at long distance <3 best >3 but not at short >2 / <4 so they >4*
@ <1 hand gesture: points at left eye >1 @ <2 hand gesture: points at right eye >2 @ <3 head movement: nods >3 @ <4 hand gesture: P and D move both hands back and forth >4		
$D:	[jaha]	*[yeah]*
$D:	**kombinerar**	***combine***
$P:	**<1 ja dom kompletterar varandra väldit <2 bra >2 >1**	***< 1 yeah they complement each other very <2 well >2 >1***
@ <1 hand gesture: D puts on a pair of glasses on P >1 @ <2 giggling >2		
$D:	**<1 <2 okej >2 <3 // >3 <4 förlåt >4 // >1** <5 om du tittar på tavlan >5 där borta	***<1 <2 okay >2 <3 // >3 <4 sorry >4 // >1*** *<5 if you look at the board >5 over there*
@ <1 hand gesture continued: D puts a pair of glasses on P >1 @ <2 quiet >2 @ <3 laughter: P >3 @ <4 gaze: D looks at the board >4 @ <5 gaze: D looks at the board >5		

The physician attempts to complete the patient's utterance by saying the word *kombinerar* ('combine'). In the subsequent utterance, the patient implicitly corrects the physician, saying that his eyes *kompletterar* ('complement') each other very well. The physician's confusion is

manifested by his saying *förlåt* ('sorry') preceded by a long pause.

In the interviews and questionnaires, the non-Swedish physicians comment on getting help from their patients, at the same time pointing out that a physician should be able to request help, which might be complicated at the beginning when one cannot explain what word is needed. Consider this comment from the Iranian physician IraD6:

De hjälpte inte [patienterna], inte på början, men nu för tiden har jag förmåga att förklara vad jag är ute efter frågar direkt: "Jag menar så och så, vad säger ni?"	*They didn't help [the patients], not at the beginning, but now I'm able to explain what I'm after and ask directly: "I mean this and that, what do you say?"*

The representatives of Swedish and non-Swedish personnel comment on helping the physicians with their language problems. While the patients help during the interaction, the health care staff members often explain to the patients after the consultation what the physicians said (N-SweN5):

När läkaren gått frågar de [patienterna] "vad sade han?" Han [den utländska läkaren] förstod inte att de [patienterna] inte förstod. Jag fick också be en annan läkare förklara.	*When the doctor has left, they [the patients] ask "what did he say?" He [the non-Swedish physician] didn't understand that they [the patients] didn't understand. I also had to ask another doctor to explain.*

In the Swedish patients' questionnaire, the respondents were asked whether any health care personnel was present during their consultation with the non-Swedish physician (Q.15), followed by questions concerning what kind of personnel were there and how they helped (Q. 16). Sixteen patients reported that a member of the health care personnel had been present during their consultation with a non-Swedish physician; only three of them considered that that person had helped the physician with language. In all cases it was a nurse, who helped with pronunciation, word-finding problems, and sentence construction, as well as providing more detailed information to the patient. Only one example from the recorded data is available to illustrate this (see below):

Example 15. "I want my X-ray pictures" (IraD8)

Patient insisting on having his X-ray pictures send home

Speaker	**Transcription**	**Translation into English**
$:P	ja å så skulle ja gärna vilja ha kopior på dom röntgenbilderna också	*I would like to have copies of these X-ray pictures*
$D:	röntgenbilderna	*X-ray pictures*
$P:	ja kopior på dom	*yes copies of them*
$D:	okej vi kan skicka till din adress	*okay we can send them to your address*

The physician agrees to send the copies of the X-rays to the patient. However, the nurse immediately objects, pointing out that it is not the *copies of the X-ray pictures* but *the copy of the answer* from the physician who analyzed the pictures that can be sent to the patient:

Example 16. "I want my X-ray pictures" (IraD8) (cont.)

Speaker	Transcription	Translation into English
$N:	**men röntgenbilderna kan du inte få kopia på då får du få på [1 kopia]1 på svaret [2 då]2**	***but you can't have a copy of the X-ray pictures but you may have a [1 copy]1 of the answer [2 then]2***
$D:	[1 men]1	*[1 but]1*
$D:	[2 svar]2 [3 (mina vän)]3	*[2 answer]2 [3 (my friend)]3*
$P:	[3 ja]3 vill ha på bilderna	*[3 I]3 want a copy of the pictures*
$N:	[4 (de går inte)]4 nej	*[4 (it's not possible)]4 no*
$D:	[4 (...)]4	*[4 (...)]4*
$P:	[5 (jo jo)]5	*[5 (why yes yes)]5*
$D:	[5 (...)]5	*[5 (...)]5*
$P:	de e klart mina bilder	*of course these are my pictures*
$N:	**nej (...) kan man inte få men du kan få kopia på [6 svaret]6**	***no (...) you can't have but you may have a copy of the [6 answer]6***
$D:	[6 svaret]6 kan du få	*[6 the answer]6 you may have*

There are two possible causes for the nurse's intervention: the physician's lack of knowledge of routines in the hospital or failure to understand what the patient meant.

This section (and the earlier ones) exemplifies how cooperation works across language and cultural borders in a specific social activity – medical consultation. According to Allwood (1976, 2007b), cooperation is a matter of degree; one can be cooperative to a greater or lesser extent. Allwood (2007b) presents four conditions for cooperation; if all of them are followed, an ideal level of cooperation can be observed, but if at least one condition is followed, one can speak about some degree of cooperation. Two or more normal rational agents interact cooperatively if their actions fulfill the following four conditions:

- take each other into cognitive consideration
- have a joint purpose
- take each other into ethical consideration
- trust each other to act in accordance with (i) – (iii)

(Allwood, 2007b, p. 1)

We can observe that the patients and the non-Swedish physicians take each other into **cognitive consideration**. They adjust their communication to each other, taking into account the limitations and possibilities of their interlocutor's cognition. The patients of the non-Swedish physicians help their physicians with language when they notice them experiencing language problems of different kinds, and the non-Swedish physicians ask their Swedish patients for language help (though seldom, as can be seen from the data). At the same time, the non-Swedish physicians are often aware of their patients' problems with understanding medical terms, and, as can be seen from one of the examples from an interview (p. 87), they attempt to explain terminology (e.g., multicystisk = många påsar som hänger tillsammans). Because they are aware that language problems can influence understanding (see 4.3.3.), the non-Swedish physicians also attempt to be as clear as possible, according to their patients (see section 4.6, in which I discuss positive aspects).

Physician and patient, whether they come from the same or different cultural backgrounds, have **a joint purpose**: to reach some kind of shared understanding of the patient's problem in

order to fulfill the purpose of medical consultation as a social activity, namely to solve or help to solve the patient's health problems. Though it is the physician who is primarily responsible for the interaction, both participants are interested in achieving successful communication during the consultation to get a clear picture of the problem. This should result in the Swedish patients' actively helping their physicians in case of language difficulties, both at the physician's request and otherwise, as it is a way for them to get the help they need; meanwhile, the non-Swedish physicians should allow their patients to help them and use this help. However, here ethical aspects come into play. The fact that the patients report that they seldom provide help, and in fact are rarely observed to do so, may be traced back to their **ethical consideration** of the physicians, such as fear of showing disrespect to the physician by correcting his/her language. In addition, the typical Swedish conflict avoidance and unease with confrontation may be relevant here. On the other side, although the physicians might accept that it is rational to use their Swedish patients as a kind of "language support tool," fear of being seen as "unprofessional" and "linguistically incompetent" might prevent them from doing so (see section 4.5 below). This might be especially true of the representatives of cultures in which a greater distance between physician and patient is preferred and the physician's status is emphasized. All the factors mentioned above indicate that there might be a lack of mutual **trust** in intercultural medical consultations, which is unfortunate, as trust is one of the prerequisites for successful cooperation.

Before turning to the issue of trust, one question arises: Where does the physicians' impression that the patients are helping them with language problems come from (86% of the non-Swedish physicians report getting help at least sometimes)? I would explain this by the novelty of the situation for the non-Swedish physicians (i.e., being in the role of a non-native physician and working in a foreign country). In addition, the non-Swedish physicians might be unused to the patients' getting involved to such an extent compared to their experiences with patients from their home countries (see section 4.3.1 discussing the differences between patients from other countries and Sweden). One might also presume that in cultures that maintain a larger power distance and a more paternalistic relationship between physician and patient (as we have seen, the majority of the non-Swedish physicians come from countries that have larger power distances than Sweden), patients might consider it to be "rational" not to correct or help a physician during consultation (a face-saving strategy). In Swedish culture, which, as discussed above, is characterized by a short power distance and questioning of authority, patients might not see saving the physician's "face" as rational to the same extent as in more hierarchical cultures. This factor might also influence how the non-Swedish physicians perceive their patients' involvement.

Trust, the fourth premise for cooperation, is the participants' belief that "the other communicators are cognitively and ethically considering them as well in trying to achieve common understanding or other joint purposes" (Allwood 2007b, p. 10). As the responses to questions 29 (non-Swedish physicians) and 23 (Swedish patients) in section 4.2.1 show, trust is an essential aspect of medical consultation. It is seen as the basis for the physician-patient relationship and a prerequisite for patient satisfaction, as the research shows (McKinstry et al., 2006; Janssen et al., 2007). A patient's trust in his/her physician, which is often seen as "the [patient's] belief that a doctor is working in the patient's best interests" (McKinstry et al., 2006, p. 2) results in openness and an ability to tell the doctor all the information relevant to his/her health problem so that the doctor can make an accurate diagnosis and prescribe

treatment. Here, it is worth mentioning that it is primarily patients' trust in physicians rather than physicians' trust in patients that is the focus of research. This is not surprising, as in consultation it is the patient who is in a vulnerable position and has to disclose himself/ herself to a physician (often a complete stranger), while the physician must make the patient feel comfortable enough to do this. However, the physician's trust in the patient is no less important. Lack of trust on the physician's side might result in, among other things, questioning what the patient says, which could have negative outcomes such as refusing to provide medical treatment, which the patient might actually need.

Developing trust across linguistic and cultural borders is not always unproblematic, as differences in values, anxiety and uncertainty (see, for example, Gudykunst's anxiety/ uncertainty management theory; Gudykunst, 1988), cultural biases and language problems are often obstacles to constructing a shared understanding and building trust. In intercultural medical consultation, differences between the physician's and patient's views of health and illness, roles and outcomes of the consultation, for example, might influence the development of trust between them.

Let us return to example 1 ("You don't need care"), in which the German physician tells his patient that he did not observe anything that shows that she needs medical help. The patient seems skeptical about what the physician says and may have the impression that the physician is not taking her problem seriously, is being unethical (offensive, insulting) in delivering his diagnosis, does not want to help her, etc.; in fact, the problem might stem from the physician's experiencing language problems and being used to a different communication style (a more direct way of speaking).

It is also possible that the physician simply does not consider the patient's symptoms as being the kind that need to be treated. Earlier in the interaction, the patient points out that the physician who treated her before made a diagnosis of *fibromyalgi* ('fibromyalgia'):

Example 17. "Fibromyalgia" (GerD12)

Speaker	Transcription	Translation into English
$P:	m // och sen så e så undersökte hon mej å konstatera att ja även hade fått fibromyalgi	*m // and then er she examined me and stated that I also had fibromyalgia*
$D:	m	*m*
$P:	för att ja hade fått ont på mer ställen i [kroppen]	*because I had pain in more parts of [the body]*
	[m] < /// m: // >	*[m] < /// m // >*
@ < hand gesture: D is writing >		

The symptoms of fibromyalgia are relatively easy to fake (Khostanteen et al., 2000). It is possible that the physician might think that the patient is simulating and the patient might think that the physician mistrusts her story. In any case, this situation exemplifies a lack of trust between physician and patient, which, unfortunately, can result in negative outcomes.

The patient might also be suspicious of the quality of the physician's education (this may be especially true for physicians from developing countries), which is negative for developing trust in consultation. Thus, the fact that non-Swedish physicians are rarely observed explicitly asking for help from their patients may be related to their attempt not to show any lack of language competence, which, as I will show below, could have a negative impact on the patients' view of their professional competence – "bad Swedish = bad doctor" – and,

consequently, their patients' trust in them as physicians.

As I have discussed, a number of studies report a relationship between non-native physicians' language proficiency and their patients' view of their professional competence. Fiscella et al. (1997) point to the "fear of patient bias" (i.e., the non-native physicians' feeling that their professional competence is considered worse than that of native physicians). One might ask, do non-Swedish physicians believe that Swedish patients are unable to distinguish between their professional and linguistic competence? Questions concerning this issue were addressed to both the non-Swedish physicians (Q.28) and the Swedish patients (Q.25) (i.e., whether the patients found that a physician's language competence influenced their impressions of him/her). The respondents' views on this issue are presented below.

4.5 The relationship between language proficiency and professional competence

The confusion of general competence and linguistic competence, which often leads to discrimination, is a general problem in intercultural communication. Low competence in the language of the host society often limits career opportunities. Unlike discrimination based on, for example, religion, race, gender, or clothing style, language competence often reflects the immigrant's interest in the host culture, willingness and ambition to learn and to "become part" of society as well as, to some extent, his/her general intelligence level; having a good knowledge of the language enables one to be a more competent interlocutor and makes it possible to demonstrate one's professional competence (in our case, medical knowledge).

Consider the following comment from a Finnish physician (FinD22):

Svensk går ut och bedömer doktor med sina svenska ögon ofta pga. bristande språket ifrågasätter kunskapsnivån. Man blandar ihop den. Den som inte kan språket kan ju inte kunna läkarvetenskapen heller. Min erfarenhet är att de utländska läkarna ofta har stora kunskapsnivåer, ofta djupa kunskaper på sitt område.	*Swede goes and judges doctor with his Swedish eyes often because of failing language questions, the level of knowledge. One mixes it up. Someone who doesn't know the language can't know medicine either. My experience is that the foreign doctors often have high levels of knowledge, often deep knowledge in their field.*

Language problems might be a reason why patients question a physician's professional competence and professionalism. This issue was addressed in the questionnaire and the interviews with both the non-Swedish physicians and the Swedish patients. The responses obtained to the questionnaire are presented in Table 43.

Table 43: Non-Swedish physicians and Swedish patients: linguistic competence and professional competence (Q. 28 and Q.25)

Non-Swedish physicians (Q.28)

Question	**Alternatives/number and % of respondents per alternative**			**# of resp.**
Have you found that Swedish patients mixed up your language competence with your professional competence?	Yes	No	Sometimes	
Non-Swedish physicians	14 18%	42 54%	22 28%	78
Male	8 16%	26 52%	16 32%	50
Female	6 22%	16 57%	6 22%*	28
*The numbers do not add up to 100% because of rounding.				

Swedish patients (Q.25)

Question	**Alternatives/number and %* of respondents per alternative**						**# of resp.**
Does the non-Swedish physician's language competence influence your first impression of his/her ...	Professional competence	Professionalism	Ability to make me feel secure	Ability to understand me	No influence	Other	
Swedish patients	8 10%	9 11%	24 29%	35 43%	33 40%	2 2%	82
Male	3 7%	4 10%	12 29%	17 41%	18 43%	1 2%	42
Female	5 13%	5 13%	12 30%	18 45%	15 38%	1 3%	40
*Percentages exceed 100% because the total is based on respondents and each respondent was allowed to give more than one response.							

To start with the **physicians**, even though the alternative "no" was chosen by 54% of respondents, the remaining non-Swedish physicians had found that their patients confused their professional and language competence regularly (18%) or at least sometimes (28%). The female respondents were slightly more likely than the males to choose the alternative "no." No clear tendencies can be observed in the answers of the physicians from different cultural groups.

Concerning the Swedish **patients**, such alternatives as "ability to understand me," "no influence" and "ability to make me feel secure" have the highest response frequency. Only 10% and 11% (21% total) chose the alternatives "professional competence" and "professionalism." The female patients chose these alternatives more than the males (females 26% [13% + 13%] and males 17% [10% + 7%]). The comments mentioned in response to the alternative "other" relate to anxiety and uncertainty about the correctness of the diagnosis.

Concerning the patients' **age** and **education** (Appendix E), the younger female and older male patients chose the alternatives "professional competence" and "professionalism" more than the older female and younger male patients. Both male and female patients with primary education were less likely to choose the above-mentioned alternatives than the respondents with secondary and postsecondary education.

Concerning differences in the same-sex and cross-sex encounters, the following picture emerges:

Table 44: Swedish patients: non-Swedish physician's linguistic and professional competence (same-sex and cross-sex medical encounters, Q.25)

Question	**Alternatives/number and %* of respondents per alternative**					**# of encounters**
Does the non-Swedish physician's language competence influence your first impression of his/her ...	Professional competence	Professionalism	Ability to make me feel secure	Ability to understand me	No influence	
M phs–M pat	2 6%	3 9%	10 29%	14 41%	15 44%	34
M phs–Fpat	5 16%	4 13%	11 35%	12 39%	14 45%	31
F phs–F pat	0 0%	0 0%	1 11%	6 67%	2 22%	9
F phs–M pat	1 13%	1 13%	2 25%	3 38%	5 63%	8
* Percentages exceed 100% because the total is based on respondents and each respondent was allowed to give more than one response.						

The table shows that professional competence and professionalism appear to be questioned by the patients most in the cross-sex medical consultations: M phs–F pat (16% + 13% = 29%) and F phs–M pat (13% + 13% = 26%). None of the female patients who had experienced communication with female physicians and only 5 of the 34 male patients (15%) who had communicated with male physicians report questioning their professional competence or professionalism. Concerning the choice of other alternatives, the female patients were less likely to find that a physician's language competence influenced his/her ability to make them feel secure (F phs–F pat 11%) while the opposite was true of the female respondents' communication with male physicians (M phs–F pat 35%).

In the interviews, the non-Swedish physicians commented that they had found that both patients and personnel mixed up their linguistic and professional competence (IraqD14):

> ja, ibland tycker de [personalen] det är språkliga svårigheter, men ibland – nej, han är inte så duktig på medicin, om man faller första månaden är det svårt att fortsätta, är det svårt att få plats i det medicinska samhället ... bedömmer de [personnel] honom negativ första månad, kan han inte rengöra bilden.
>
> *yes, sometimes they [the personnel] find that there are linguistic problems, but sometimes – no, he is not that good at medicine, if one fails the first month, it's difficult to continue, it's difficult to enter in the medical society ... if they [the personnel] evaluate him negatively the first month, he cannot clean up the picture.*

To summarize, about half of the non-Swedish physicians report experiencing their language competence being considered to represent their professional competence; the male physicians experience this more than the females. A physician's professional competence and professionalism are most often questioned by patients in cross-sex consultations and least in female-female consultations. No clear pattern can be observed between the patients' questioning of physicians' professional competence or professionalism in relationship to age. As for education, the patients with primary education appear to question their physicians' professional competence less than more educated patients. It is interesting that female patients

report experiencing that female physicians' language competence has little influence on their ability to make them feel secure, whereas with the male physicians, it does have an impact.

As we can see, the non-Swedish physicians are more likely than the Swedish patients to report experiencing their professional competence being confused with their language competence; one might attribute this to the non-native respondents' general uncertainty and increased sensitivity. On the other hand, the Swedish patients might be uneasy reporting their experiences. Concerning gender, the male non-Swedish physicians report experiencing "patient bias" to a somewhat higher degree than the females; one might speculate that the male respondents are more concerned with status. The fact that the better-educated patients question the physicians' competence more than the less-educated patients may be explained in the same way as the satisfaction issue. I cannot provide a good explanation of the pattern observed in cross-sex and same-sex medical consultations.

4.6 Reported positive aspects of intercultural medical consultations

The Swedish patients and health care personnel in our survey were asked to comment on what was positive about meeting a non-Swedish physician during a consultation. The Swedish patients were asked about this both in the questionnaire (Q.20) and in the interviews, while the medical personnel were only asked about the topic in the interviews. To start with the Swedish patients, the following responses were obtained:

Table 45: Swedish patients' comments on the positive aspects of meeting a non-Swedish physician

Comments from the Swedish patients in response to the question: "What was positive about your visit to the non-Swedish physician?"		
	Swedish original	**English translation**
Listening, thorough, caring, and taking time	Läkaren lyssnade bra och verkade på det stora hela seriös	*The physician listened well and seemed serious in general*
	Att läkaren var noggrann och tog mig på allvar	*That the physician was meticulous and took me seriously*
	Hon brydde sig och lyssnade och var väldigt noggrann	*She cared and listened to me and was very thorough*
	Tog sig tid; Den utländska läkaren tar sig mer tid, är mera noggrann	*Took his time. The non-Swedish physician takes more time, is more meticulous*
	Noggrann och omsorgsfull	*Thorough and careful*
	Känns som om utländska läkare bryr sig mer och är mer mån om en	*It feels like non-Swedish doctors care more and are more concerned about you*
Proffessionalism and competency	Hans kunskaper	*His knowledge*
	Att läkaren kunde sin sak; hans kunnighet	*That the physician knew his business; his competence*
	Han var duktigt och proffs; kunnig läkare	*He was skilled and professional; competent physician*
	En bra – duktig läkare svensk eller utländsk är helt OK (bör kunna svenska bra)	*A good – skilled doctor; Swedish or non-Swedish is quite OK (should be good at Swedish)*
Interest	Han var intresserad av min transplantation (lever)	*He was interested in my transplant (liver)*
	Lugn och proffsig (erfaren)	*Calm and professional (experienced)*

Calmness, directness, clearness	Han var mycket övertygande i sin argumentering – hade en lugnande effekt på mig. Han övertygade mig att mina "problem" inte var så "farliga"	*He was very convincing in his argumentation – had a calming effect on me. He convinced me that my problems were not "dangerous"*
	Trevlig och bestämd	*Nice and determined*
	Raka svar. Tydligt och han var ej tveksam	*Direct answers. Clear and he was not uncertain*
	Klara besked	*Plain answers*
Willingness to speak Swedish and involvement with patient and his /her problems	Intresserad, kunning- villig att försöka förklara	*Interested, competent- willing to try to explain*
	Hon försökte, hon var nog en duktig läkare	*She tried, she was probably a skilled physician*
	Han ville väldigt väl!	*He really cared!*
	Att han försökte prata svenska	*That he tried to speak Swedish*
	De verkar lite mer engagerade i mig som patient, kanske de är medvetna om att de kan bli "jämförda" med svenska läkare	*They seem somewhat more involved with me as a patient, maybe they're aware that they might be "compared" to Swedish physicians*
	Vinnlägger sig att bli förstådd och förstå	*Take great pains to understand and to be understood*
Satisfactory examination and outcome	Det som i allmänhet är positivt med läkarbesök, man får hjälp och diagnos	*The general positive aspects of a consultation, you receive help and a diagnosis*
	Informativt; även om det tog lite extra tid; Fick den behandling jag efterfrågade	*Informative; even if it took a little extra time; got the treatment I asked for*
	Gjorde en bra undersökning. Var nöjd	*Did a good examination. Was satisfied*
Other	Jag kände mig trygg; Han berättade om sin utbildning	*I felt secure; He told me about his education*
	No problems; han var lika bra som andra läkare	*No problems; he was just as good as other doctors*

Meeting a thorough, caring physician who is a good listener and has time for patients is the most common reply from the Swedish patients to the question about their positive experiences in consultations with non-Swedish physicians. Lussier and Richard (2007) point out that patients' dissatisfaction with a consultation is often related to their experiencing the consultation as being too short, which means that physicians pay less attention to their patients. The interview response from a senior Finnish physician (FinD22) both reflects and partially explains the patients' comments:

> Och just det här att man kan dra nytta av att man [utländsk läkare] är SAKTARE i sitt språk och patienten hinner så att säga mer också på ett annorlunda sätt och att man tar mer tid. Patienter mäter tiden också i faktisk tid. Om du tar 10-20 minuter längre från dig då uppfattar patienten att du ÄGNAT dig åt 10-20 minuter längre an vad en annan doktor har gjort. Så att jag tror att många patienter säger "Ja hon och han är så noggrann, vi får så mycket tid, och just det den doktor LYSSNAR. Det är oftast sådana saker som jag kan kan höra om läkare med utländsk backgrund. Det här kan vara att vad man själv uppfattar som sina svagheter kan också uppfattas som egentligen samtidigt som positiva sidor från mottagarens sida och framförallt från patienternas sida. Det är just att han eller hon tar TID.
>
> *And precisely this, that you can benefit from being SLOWER in your language [non-Swedish physician] and the patient gets more time so to speak, also in a different way, and that you take more time. Patients measure time in factual time as well. If you take 10 to 20 minutes more of your time, then the patient perceives that you have DEVOTED yourself 10 to 20 minutes more than another physician has done. That's why I think many patients say: "Yeah, she and he is so thorough, we get so much time, and precisely this, this doctor LISTENS." It's mostly things like that I can hear about physicians with non-Swedish backgrounds. It could be that what you yourself consider as your weaknesses may actually simultaneously be considered as positive aspects from the receivers' point of view and above all from the patients' point of view. It's exactly that he or she takes TIME.*

The Finnish physician's comment provides a tentative explanation of why the non-Swedish physicians are described as meticulous and as spending a lot of time with their patients.

Moreover, due to language problems, the tempo of interaction might be lower than in interactions between native speakers (which is proven by the analysis of the recorded interactions provided in Chapter 6, section 6.3 below). Consider the following comment (N-SweN4):

Man brukar alltid tala mycket långsamt och mer klart. De [utländska läkare] är medveten om deras språksvårigheter ... eftersom han talar så tydligt så egentligen är han väldigt omtyckt om patienter för han kanske talar mycket mer långsamt och klart.	*Usually one always talks very slowly and more clearly. They [the non-Swedish physicians] are conscious about their language problems ... because he talks so distinctly, he really is very popular with patients because he maybe talks much more slowly and clearly.*

I will return to the issue of meticulousness later on, when analyzing recordings of medical consultations.

Concerning the non-Swedish physicians' reported as being caring, one might presume that the paternalistic style of relationship, characterized by the physician taking the core responsibility for the patient might affect the physician's behavior and constitute the grounds for such comments. Consider this excerpt from the conversation between a female Russian physician and a male Swedish patient concerning ointment for his shoulder:

Example 18. "Ouch, it hurts" (RusD18)

Physician recommends that the patient put more ointment on the shoulder

Speaker	**Transcription**	**Translation into English**
$D:	<1 å ja ska skriva <2 ut en bra gel >/ en bra >1 sån salva >2 för axeln / **så när de liksom AJ e de svider till då får du smörja den / å de släpper** // vill du ha de så	*<1 and I will prescribe <2 a good gel / a good >1 such ointment >2 for your shoulder /* ***so when it kind of OUCH er it hurts you can rub it / and it will release // is this what you want***
@ <1 hand gesture: P takes the paper >1 @ <2 hand gesture: D touches and rubs P's shoulder >2		
$P:	aja	*yeah yeah*

The example above might also illustrate the physician treating her patient in a way that reflects the Russians' view that a physician should not only have technical knowledge but "a heart, soul" (Dohan and Levintova, 2007). The importance of relationship development and building trust, sincerity and "conversation of souls" in Russian culture have also been pointed out by Svennevig and Isaksson (2006).

Another comment made by the patients is that the non-Swedish physicians are very direct, which (as I have mentioned above) can be explained by a number of factors and may have both positive and negative consequences; for example, being too direct might create problems in delivering sensitive diagnoses. A possible positive impact of a direct communicative style can be observed in the example below, an excerpt from the interaction between an Iranian physician and a Swedish male patient in which the physician recommends that the patient should be careful with his feet:

Example 19. "Bruise" (IraD6)

Physician conducting a physical examination of a patient who has no mobility in his legs and observes a bruise on his foot

Speaker	Transcription	Translation into English
$D:	sån här blåmärke här	*such a bruise here*
$P:	a	*yeah*
$P:	e de nåt me skorna eller	*has it to do with your shoes or*
$P:	ja körde emot	*I bumped into*
$D:	**jaha < // > okej // du måste vara jätteförsikti [me dom]**	***I see < // > okay // you must be very careful [with them]***
@ < chuckle: P >		
$P:	[vet de]	*[know that]*

The Swedish patients may appreciate getting direct and clear directions from the non-Swedish physicians.

Regarding professionalism and competence, these characteristics are not necessarily related to a physician's being a foreigner but are appreciated in *any* physician. However, the paternalistic relationship style that implies that the physician is functioning as an authority might highlight the physician's role as a health care provider more than occurs in a relationship of mutuality. Consider the example below, where an Iranian physician emphasizes his experience and knowledge (IraD8):

Example 20. "I have done it many times" (IraD8)

Physician ensuring the patient concerning his professional experience

Speaker	Transcription	Translation into English
$P:	på en tre fyra dar då så e man på sjukhus på en gång va	*in three or four days then you're at the hospital at once right*
$D:	**nej de e ju helt annan / karaktär än den här som din kula ja e ju krigskirurg i botten ja har ju [opererat]**	***no it is of quite a different / character than this bullet of yours see I am a war surgeon originally so of course I have [performed surgery]***
$P:	[va] e de för skillnad då	*[what's] the difference then*

However, the patient is apparently not impressed by the physician's talk about his professional experience.

Judging from their comments, the Swedish patients appreciate the non-Swedish physicians' attempts to speak Swedish and understand what is being said. One Swedish patient comments on this in the interview (SweP2):

Det verkar så att utländska läkare anstränger sig lite mer att verkligen förstå vad patienten vill, de tar mer tid	*It seems that non-Swedish physicians make more effort to really understand what the patient wants, they devote more time.*

To summarize, the positive experiences of consultations with the non-Swedish physicians reported by Swedish patients and health care personnel are as follows. The non-Swedish physicians are described as listening, caring, and taking the time to talk to their patients. These comments might reflect the non-native speakers' being particularly attentive to what their patients say so they will not miss any

information. The language problems they experienced might result in the non-Swedish physicians' taking more time for consultation. Caring and professionalism might be linked to the physicians having a more paternalistic relationship with their patients. The physicians' clearness and directness may also be due both to their language problems and their cultural impact, that is, problems with formulations and attempts to be as clear as possible when using Swedish as a foreign language. The difference in power distance might also play a role. The patients also appreciate the physicians' speaking Swedish and being engaged in their problems. In addition, as in any consultation, a successful outcome is appreciated.

Cultural differences are often seen as an obstacle, a barrier to communication. As mentioned above, few researchers treat cultural diversity as an asset, rather than a source of problems (see Søderberg and Holden, 2002, for a detailed overview of the research on problems and benefits of intercultural diversity in business). The Swedish patients' comments about their positive experiences of medical consultations with the non-Swedish physicians show that intercultural communication and even foreign language use can have their benefits. One should not over-generalize and assume that *all* Swedish patients favor a mutuality relationship with their physicians and being involved in decision-making. Some patients may prefer a more paternalistic relationship with their physician, which often entails less patient involvement. I presume that it is primarily elderly patients who are used to a more "paternalistic physician" and might enjoy meeting with a non-Swedish physician. However, as I have already mentioned, the elderly patients might experience hearing problems and not be used to having a non-Swedish physician as a health care provider, which can also create problems with understanding and suspicion. The use of a foreign language by a physician could result in problems with understanding. However, at the same time, if the physician is aware of the possibility of lack of understanding/misunderstanding and consciously attempts to prevent these problems by speaking slowly and clearly, patients appreciate it.

I will return to the issues mentioned in this analysis of the recorded medical consultations and will try to find out what communicative strategies used by the non-Swedish physicians gave rise to these comments.

4.7 Summary of Chapter 4

In this chapter, I presented an analysis of interviews and questionnaires combined with the data from the recordings of medical consultations. First, I would like to comment again on the methodology and data. A substantial part of this chapter is based on data obtained from questionnaires sent to non-Swedish physicians and Swedish patients. It is worth pointing out that the participant groups have diverse backgrounds in terms of education, work experience, age, etc. As I have mentioned, the participants represent a wide variety of cultures, but the number of representatives of each one is relatively low. Hence, the conclusions drawn about specific cultures are often tentative.

It was difficult to evaluate the non-Swedish physicians' language competence, even though the approximate duration of their language training was mentioned in the questionnaires (Q.13, see Appendix D). Furthermore, not all factors were taken into account, such as the fact that the representatives of certain cultures might be "less favored" than others. In addition, though we have tried to find out whether the patients were aware of the cultural backgrounds of the non-Swedish physicians they met (Q. 5, 6 and 7 in the Swedish patients' questionnaire), few patients answered these questions. Furthermore, a patient's guess concerning the physician's background cannot be considered to be reliable. As I have mentioned a number of times, in some cases there are not enough data to draw any definite conclusions, for example concerning the impact of patients' age, gender and education on their evaluation of communication, the non-Swedish physicians' responses in relationship to their cultural backgrounds, communication in same-sex and cross-sex consultations, etc. Nevertheless, the data analysis reveals some insights into how intercultural communication between non-Swedish physicians and their Swedish patients plays out and to make some observations on the impact of gender, culture, age and education.

The results presented in this chapter show that there are both differences and similarities in how the non-Swedish physicians and the Swedish patients view the physician's task in medical consultation. Taking the patient's problems seriously and showing a genuine interest are tasks which both physicians and patients consider important. Confidence is also valued by both groups. This shows that there are similarities in the non-Swedish physicians' and Swedish patients' views of communication in consultation, which might result in satisfaction with communication. The fact that the physicians and patients report being generally satisfied with their communication (the majority of Swedish patients are even satisfied with communication in relation to their expectations and the amount of information provided by the non-Swedish physicians) suggests that intercultural communication can be successful, though it is not unproblematic. Both language and cultural differences are reported and are observed to interfere with interaction between the non-Swedish physicians and their Swedish patients.

Language problems are reported and observed to have a negative influence on communication more than cultural differences, which is not surprising as they are more "visible." The primary reasons for lack of satisfaction/dissatisfaction are problems with the formulation of messages including word-finding problems, problems with grammar and pronunciation (especially when combined with patients' hearing problems). The majority of problems with understanding observed in the medical consultations also have their roots in language problems.

In the case of language problems, the non-Swedish physicians report getting help from their patients and the Swedish patients report helping their physicians with language (though less than the non-Swedish physicians). In the transcriptions of the recordings, physicians and patients are observed to cooperate in order to achieve the purpose of medical consultation: to give help to the patient/get help from the physician. The analysis of interactions also shows that in most cases the non-Swedish physicians prefer to solve problems by themselves. In cases when the patient provides help, stress and confusion on the physician's side can sometimes be observed.

Language competence being confused with professional competence is reported more by the physicians than by the Swedish patients. This is especially true of the male physicians, which might reflect the greater value males attribute to status compared to females.

The **cultural differences** mentioned by the participants as influencing communication are primarily differences in power distance and Swedish conflict avoidance.

The data analysis illustrates how language and culture are intertwined in communication, as it is often not possible to trace the problem experienced by the respondents to language problems or cultural differences alone. One example of this phenomenon is the non-Swedish physicians self-reporting and being reported by the patients and personnel as being too brief, which may be explained by language problems, that is, difficulties in formulating the message. However, a cultural factor may play a role here as well, namely differences in views of physician-patient relationships related to power distance. In a more hierarchical relationship type, the physician might not consider it important to explain his/her decisions to the patient, while a Swedish patient who is used to a more egalitarian relationship might expect the physician to do just that. The fact that the non-Swedish physicians are too concise in talking to their Swedish patients and provide fewer explanations than the patients expect might be a result of their lack of language competence, but it could also stem from the physicians' not considering it necessary to do this. The lack of both language competence and cultural competence might explain the non-Swedish physicians' problems with small talk (i.e., lack of vocabulary to talk about things outside the medical field and lack of knowledge of what issues can be discussed).

Swedish conflict avoidance, fear of confrontation and indirect communication style were also mentioned by the non-Swedish respondents. Though the physicians appreciate the Swedish patients as being "kind and problem-free," many feel uneasy about the Swedish fear of showing their dissatisfaction openly. In addition, their uneasiness in talking about such sensitive "taboo" topics as alcohol was mentioned and described here.

The data analysis has also provided some insight into non-verbal communication in intercultural medical encounters. As language problems can complicate, and indeed are observed to complicate, understanding, the physicians and their patients rely on gestures as tools to support and clarify their verbal messages. Gestures are even used when the physicians experience word-finding problems and need to "substitute" the word they lack with a gesture. Concerning cultural differences, the Swedish patients are less likely to report seeing eye contact as a prerequisite of making contact than the physicians are; this can be explained by differences in cultural views of eye contact as a way of establishing contact and trust, which are appreciated in medical consultation. However, it is worth mentioning here that gender may also have an influence.

The analysis also provides some insights into **Swedish culture and the cultures of the non-Swedish physicians**. The fact that Swedish patients are critical of physicians might be rooted in a cultural attitude that is critical of authorities (as well as a possible attempt by the non-Swedish physicians not to report any lack of satisfaction in order to avoid reporting failure). One can also observe German directness in contrast to Swedish indirectness. Here, we can see that, although the German physicians report experiencing more differences than other non-Swedish physicians, they are also among the most satisfied. This illustrates that cultural differences do not necessarily lead to a lack of satisfaction. In addition, the German physicians' higher satisfaction with regard to cultural understanding compared to other groups might tentatively be explained by the closeness of German and Swedish culture. The fact that the respondents from Northern Europe prefer to be more neutral, choosing the alternative "satisfactory" to describe their communication with their Swedish patients, might reflect the differences between cultures of understatement and overstatement. The data also shed light on certain aspects of Swedish culture, such as the Swedish patients' lower preference for eye contact compared to the representatives of other cultures (non-Swedish physicians) and their relative informality in consultation. The data analysis indicates that a Swedish consultation is experienced as being quite informal by the non-Swedish physicians, though this does not necessarily cause them to change their communicative style and become more informal themselves.

The data also show how **the non-Swedish physicians experience being newcomers in the language and culture of their patients and using Swedish as a foreign language in consultation**. I presume that the fact that the physicians (both male and female) value making personal contact might show their need to overcome language and cultural barriers between themselves and their patients. The non-Swedish physicians who chose the alternative "to show professional competence" in response to the relevant question are predominantly physicians from the countries outside the European Union, which might indicate that they feel more need to prove their professionalism to the patients than physicians from within the EU/EEA. In addition, cultural views of the physician's role might play a role here. The Hungarian physicians' lower satisfaction with their language is probably related to their being the group that had spent least time in Sweden, which might influence their language competence.

The data also provide some insights into the **physicians' and patients' views of medical consultation as a social activity and its outcomes.** The physicians are less likely than the patients to report problem solving and showing professional competence as primary tasks. The patient wants to solve his/her problems, while the physician understands that this is not always possible.

Apart from the physicians being foreigners and their patients being native speakers, a number of other factors are observed to influence how the respondents view their communication. One of them is **gender**. Although there are not enough data to draw definite conclusions, it can be observed that the female non-Swedish physicians and the female Swedish patients are more critical of their communication than the male respondents. The female non-Swedish physicians are less satisfied with their communication with Swedish patients and experience more differences in how Swedish patients talk to them compared to patients from their home countries; they also change their communicative style more than males do. Female physicians also report getting less help from their patients. However, the female non-Swedish physicians

report less misunderstandings than male physicians. No difference in experiencing "fear of patient bias" between male and female physicians is observed. The female Swedish patients, like the female physicians, are less satisfied than the male patients with their communication in general, and with regard to expectations and explanations in particular. They also report being more likely to confuse the physicians' language and professional competence than the male patients and report more differences in how Swedish and non-Swedish physicians talk to them. The female patients consider that they help the non-Swedish physicians more with language problems than the male patients. In addition, concerning the Swedish patients' views on communication in same-sex and cross-sex medical consultations, the female patients meeting with female physicians (F pat-F phs consultations) are less satisfied with communication in general, and in regard to expectations and explanations in particular; they report experiencing more cultural differences and more misunderstanding. The consultations between male patients and male physicians are characterized by more reported satisfaction on the patients' side and fewer cultural differences. At the same time, competence appears to be more questioned in cross-sex than in same-sex consultations; it is questioned least by female patents interacting with female physicians.

I tentatively explain the female respondents' more critical view of communication by females' higher demands for relationship development and affective communication, while males have higher demands for problem solving. (This is supported by the responses to the question concerning views of the physician's tasks: more males than females chose the alternative "to solve problems.") Relationship development may require more advanced linguistic and cultural competence, which might be complicated to achieve in intercultural medical encounters.

It is interesting that the analysis of the data for this thesis both supports and raises doubts about earlier research on gender and communication. As I mentioned in Chapter 2, earlier research shows that female patients are more critical than male patients and that the male patients are more focused on problem solving in consultation than female patients. The same conclusions can be drawn from the results of my study. However, the claim that female patients prefer female physicians can be questioned (Kerssens et al., 1997, Derose et al., 2001), as the female patients who had communicated with female physicians in this study were often more negative about their communication than the patients in other gender combinations.

Other factors are the patients' **age** and **education**. The older and less-educated patients appear to be less critical about their communication with the non-Swedish physicians than the younger and better-educated patients. In addition, more-educated patients report helping more with language. This may be due to their views on authority and difference in education.

As I have discussed, much research in the field of intercultural communication highlights the negative, rather than positive consequences of cultural meetings. Problems with understanding due to the use of a foreign language and differences in values, conflict, stress and anxiety are often mentioned. The positive effects of intercultural consultations reported by the participants in this study are that the patients get more time for consultation and they find the non-Swedish physicians to be very meticulous, which has its roots in the physicians' uncertainty with language and striving for understanding.

Chapter 5: Analysis of some specific aspects of medical consultations

In Chapter 4, I presented an analysis of the participants' views of their communication as revealed in interviews and questionnaires. In contrast, this chapter is mainly based on the analysis of recordings of medical consultations, though I bring in evidence from the interviews and the questionnaires when applicable. Below, a brief overview of the contents of Chapter 5 is provided.

Table 46: Layout of Chapter 5

Section #	Title	Empirical data used
5.1	Information seeking in intercultural and monocultural medical consultations: analysis of questions used by physicians and patients in medical consultations	recordings of medical consultations questionnaires interviews
5.2	Information giving in intercultural and monocultural medical consultations: analysis of the use of the pronoun *man* ('one')[20]	recordings of medical consultations questionnaires interviews
5.3.	Information acknowledgement and checking in intercultural and monocultural medical consultations: analysis of repetitions and reformulations as a type of feedback	recordings of medical consultations questionnaires interviews
5.4	**Summary of Chapter 5.**	

20. More specifically, I will analyze and compare the use of impersonal pronoun *man* ('one') by the physicians when they answer their patients' questions, provide explanations, give advice, etc., since differences in the use of *man* ('one') when providing information were found between Swedish and non-Swedish physicians.

5.1 Information seeking in intercultural and monocultural medical consultations: analysis of questions used by physicians and patients in medical consultations

In this section, I will provide a description and a comparative analysis of how the non-Swedish and Swedish physicians and their respective patients ask questions.

One of the tasks that both physician and patient face during a consultation is to get information from each other. The physician has to obtain information from the patient in order to make the diagnosis and suggest medical treatment. The patient, in his/her turn, is often interested in getting information from the physician concerning such issues as the advantages and disadvantages of treatment, occurrence of symptoms, etc. Since questions are perhaps the most common instrument for getting information, I have made a fairly detailed study of what question types (and how many instances of each) are used in intercultural and Swedish-only medical consultations.

It is undoubtedly essential for the quality of communication for both physician and patient to be able to get information from each other. However, as it is the physician's task to figure out what is wrong with the patient and make a diagnosis, his/her ability to ask questions is key. Naturally, when the physician is a foreigner and experiences language problems, the patient's may well feel anxious concerning the physician's ability to collect the relevant information and, consequently, to make a correct diagnosis and provide appropriate treatment.

Another reason for analyzing questions is the fact that questions are a kind of tool for establishing power in interactions. A participant who asks more questions than his/her interlocutor has more control over the person who has to answer them. (I will discuss the relationship between questioning behavior and power in more detail in the next section.) Given that power is one of the issues analyzed in this thesis, the study of question types and their use might provide some insight into the differences and similarities in how power is exercised in intercultural medical encounters (where the physicians are non-native speakers and the patients are native speakers) compared to Swedish-only medical encounters. Furthermore, I will also investigate the questioning behavior in relationship to gender and physicians' cultural backgrounds.

Turning to the questionnaire, one of the questions for the Swedish patients concerned whether there are differences in Swedish and non-Swedish physicians' questioning behavior (Q.27). The following responses were obtained:

Table 47: Swedish patients: difference in questioning between non-Swedish and Swedish physicians (Q. 27)

Gender

Question	**Alternatives/number and % of respondents per alternative**			**# of resp.**
Have you found that non-Swedish and Swedish physicians ask questions in different ways (i.e., more or less direct questions)?	Yes	No	Don't know	
Swedish patients	18 21%	53 63%	13 16%	84
Male	9 20%	28 64%	7 16%	44
Female	9 23%	25 63%	6 15%*	40
*The numbers do not add upp to 100% because of rounding.				

Same-sex and cross-sex medical encounters

Question	**Alternatives/number and % of respondents per alternative**			**# of encou nters**
Have you found that non-Swedish and Swedish physicians ask questions in different ways (i.e., more or less direct questions)?	Yes	No	Don't know	
M phs–M pat	6 17%	24 69%	5 14%	35
M phs–Fpat	9 28%	19 59%	4 13%	32
F phs–F pat	0 0%	6 75%	2 25%	8
F phs–M pat	3 33%	4 45%	2 22%	9

The majority of the patients, both male and female, report no differences between Swedish and non-Swedish physicians in asking questions (64% male and 63% female). The fewest differences were experienced by the patients in same-sex encounters: the answer "no" was chosen by 69% of male patients who had communicated with male non-Swedish physicians (M phs–M pat) and 75% of female patients who described their communication with female physicians (F phs–F pat).

The comments obtained concerning differences in questioning show that the questions asked by non-Swedish physicians are shorter, less detailed and more direct: *Kortare [frågor]. Ibland lite stress* ('Shorter [questions]. Sometimes little stress'), *Min erfarenhet av svenska läkare ställer fler, utförligare och mer bredd på sina frågor* ('My experience of Swedish physicians is that they have wider coverage in their questions'), *Mer direkta frågor. Korta frågor* ('More direct questions. Short questions').

Apart of providing grounds for speculation and further analysis of data, it is difficult to draw any firm conclusions on the basis of the questionnaire results.

5.1.1 Studies on questions in medical encounters

Questions in medical encounters have been studied from different perspectives, using different methodologies and focusing on different aspects. Below, I outline the most common issues analyzed, the results obtained and the data and analysis methods used in health care communication research.

To start with a definition, questions are often defined on the basis of their function (a request for information), following in the classical linguistic theory of speech acts (Austin, 1962). For example, in t*he Svenska akademiens grammatik* (SAG) a question is "språkhandling som innebär att talaren begär information av lyssnaren" ('speech act that implies that the speaker is asking for information from the listener'; Teleman et al., 1999, vol. 1, p. 173; our translation from Swedish). Concerning expressive form, a question can not only be expressed in the regular interrogative form, that is, the inversion of subject and verb in Swedish, the sequence auxiliary-subject-verb in English, wh-question, rising intonation, etc. In interaction, utterances such as declaratives that do not have interrogative forms can also function as questions. At the same time, utterances with interrogative forms may not function as questions (e.g., rhetorical questions, which do not have a primary function of requesting information).

As Wynn (1995) points out, the research in the field of medical consultation is represented by two approaches, namely the medical (psychological) approach, represented by Bales' (1950) Interaction Process Analysis and Byrne and Long's (1976) system of analysis on one side, and the ethnomethodological conversation analysis (CA) approach on the other. Bales' approach to the analysis of small group interactions focuses primarily on contents. Probably its most popular successor today in the field of physician-patient communication research is RIAS (The Roter Interaction Analysis System). Developed by Debra Roter (Roter, 2006) and used primarily in medical studies, the RIAS coding scheme contains 39 categories, subdivided into socioemotional and task-focused groups (15 and 24 categories, respectively). Questions are coded according to both form and content (i.e., "asks closed-ended question – medical condition" describes a yes/no question in which information about the patient's medical condition is requested). It should be mentioned here that it can be problematic to code whether a question concerns the medical or the social condition, as they might overlap. In addition, concerning question forms and the answers that are expected for each question type, Roter distinguishes between closed-ended questions, defined as "direct questions that ask for specific information, i.e., where short responses are generally the only response options and an answer of one or two words or a 'yes' or 'no' is usually sufficient" and open-ended responses, which are characterized by "non-specificity and/or probing intent" and often begin with "what, why, could or how" and request an answer of perception, information, or feelings (p. 33). This is quite common but also a rough distinction (which is not unproblematic, see below). Wynn (1995) provides a detailed overview of the criticisms of this kind of analysis, including claims that the categories are too abstract, ignore rare behaviors, have low sensitivity, etc.

On the contrary, within sociolinguistics and the CA tradition, more emphasis is placed on both the definition and linguistic analysis of questions, the form of the question, the answers obtained and the construction of turns in which the question occurs.

Such studies as those by Ainsworth-Vaughn (1998), Wynn (1998), Lindholm (2003) and Linell et al. (2003) are examples of more thorough research on questions, their forms and

functions in general, and their use in medical consultation in particular. In CA, one of the units of conversation is the adjacency pair, which consists of an exchange of one turn[21] each by two speakers; the first turn establishes an expectation concerning the second turn that will follow, for example, greeting-greeting or question-answer (Ainsworth-Vaughn, 1998). The definition of question as "ett bidrag som uppmannar till respons" ('contribution that requires a response') used in Lindholm (2003, p. 50) is based on the adjacency pair concept.

In conversation, it is not uncommon for more than one question to be asked per turn. Lindholm (2003) analyzes questions in medical consultations with regard to the turns in which they occur. *Single-unit questioning turns* and *multi-unit questioning turns* have been distinguished. The term "turn constructional unit" (TCU), originally introduced by Sacks et al. (1974), is used in CA in analyses of turn-taking. Selting (2000) says that the TCU is an intuitive and holistic notion and defines it as "the smallest interactionally relevant complete linguistic unit, in a given context, that is constructed with syntactic and prosodic resources within their semantic, pragmatic, activity-type-specific, and sequential conversational context" (p. 477). Four types of TCUs are distinguished, namely word or lexical units, phrasal units, clausal units and sentential units.

Single-unit questioning turns (SUQT) are turns that consist of only unit, so-called *enkel fråga* (simple question) (Lindholm, 2003). Such question types as yes/no questions, free-standing nominal phrases, fill-in-the-blank questions, wh-questions and declaratives have been distinguished in the data (Lindholm, 2003). Unlike single-unit questioning turns, many questions do not have a single interrogative sentence format, but rather a multi-unit design; they are defined as multi-unit questions or multi-unit questioning turns (MUQT) (Linell et al., 2003). To be called an MUQT, the turn should fulfill two conditions:

> consist of two or more turn-constructional units (TCUs), which are delivered together, either in one single turn or in a close-knit turn sequence with no intervening substantial responses from the responder [...] (i.e., we allow nothing more than receipt or acknowledgment tokens to intervene)[22].
>
> one or more of the TCUs are formally designed as questions or, more precisely, interrogatives, that is, such a TCU is marked by one or several interrogative indicators. A TCU within a MUQT is prototypically clause-shaped, although we count some phrasal units, that is, units which are not (full) clauses, as primarily components (TCUs) of MUQTs, provided that they are prosodically exposed and demarcated as units, that is, with a clear intonational terminal.
>
> (Linell et al., 2003, p. 540)

The authors rely largely on research by Heritage and Greatbach (1991) and Mazeland (1992), who call the same phenomenon a "question delivery structure" and "question delivery unit,"

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21. In my analysis, I use the term "turn" since it is used in the research I consulted in my study (in CA, turn is an important unit). However, I prefer the term "contribution," since "turn" can be problematic as a participant may make a contribution without having a turn or may have a turn without using it to make an active contribution (e.g., in cases of giving feedback or being silent). For more information, see Allwood et al. (2000).

22. Lindholm (2003) uses even narrower criteria, not including in MUQT questions that are interrupted by receipt or acknowledgment tokens from the interlocutor.

respectively. MUQT types and analysis are discussed in greater depth in section 5.1.4.

Other issues discussed in relationship to the analysis of questions in medical encounters are power, gender, culture and ethnicity.

Power and the use of questions in medical consultation is one of the central issues in physician-patient communication research. Studies show that physicians ask more questions than their patients, which results in asymmetric interactions (e.g., Ainsworth-Vaughn, 1998; Lindholm, 2003). Concerning question types, the use by physicians of closed-ended questions is helpful to obtain precise and to-the-point responses from patients, but is also often seen having negative consequences such as physicians controlling their patients, limiting their responses and not allowing them to present their problems properly (Wynn, 1998). On the other hand, open-ended questions give the patients more space to respond and increase patient participation in a consultation (for an overview of research see, for example, Wynn, 1998; Zandbelt et al., 2005). At the same time, as Gnisci and Bonaiuto (2003) point out, wh-questions (open-ended questions) differ in their degree of "openness"; the authors distinguish between broad and narrow wh questions on the basis of how specific the information is that the speaker wants to get from the listener (e.g., "How many million?" versus "What do you think?"). To sum up, though some research points to the physician's use of closed-ended questions as a sign of higher physician power, this is a somewhat oversimplified view as some open-ended questions also limit the patient's responses to a high degree, whereas responses provided to closed-ended questions are often not limited to yes/no.

Apart from the use of questions by the physicians, power relationships are also discussed in relation to the patient's questioning behavior. The issues of patient passivity and involvement in the consultation are often discussed in relation to questioning behavior or, to put it simply, how many questions the patient asks. Health care providers ask considerably more questions than their patients, but it is not clear how great the difference is. For example, West (1984) showed that patients asked only 9% of the total questions, while Ainsworth-Vaughn (1998) found that patients asked about 39% of questions. In comparing her results with West's, Ainsworth-Vaughn draws attention to the differences in genre between consultations as well as to such factors as patients' social background, first visit or not, gender, nature of diagnosis, individual differences, private vs. public health care settings, and ethnicity, which were not taken into account by West. According to Ainsworth-Vaughn, the patients who asked the most questions were in money-handling professions and white, while in West's study, approximately half the patients were black (which, according to Ainsworth-Vaughn, might be a factor explaining the considerably lower number of questions asked by West's patients). The majority of interactions in West's study were with male physicians, while in Ainsworth-Vaughn's study, the numbers of male and female physicians was equal. Therefore, racial differences, gender and social status appear to influence questioning behavior and, consequently, the power relationship in consultation. Černý (2004) also points out that patients ask more questions in certain phases of consultations; in his study, no patient-initiated questions were observed during the history-taking phase of consultation.

To be more specific about **gender**, Ainsworth-Vaughn (1998) showed that, in interactions with female physicians, the number of questions asked by male and female patients was roughly similar; when the physician was a male, female patients asked more questions than male patients. Male physicians are also reported to ask more questions than female physicians. Conversely, Wynn (1995) reports male physicians and patients to have higher

mean numbers and frequency of questions than female physicians and patients. As for the types of questions asked, no differences were observed in relation to gender (Roter et al., 2002).

Concerning relationship between **culture and the questioning behavior** of participants in medical consultation, few studies exist. The study by Ohtaki et al. (2003) shows no differences in questioning behavior in terms of distribution of question types and number of questions asked by the physicians and patients in the USA and Japan; in both countries, the physicians asked more questions than the patients and the distribution of question types was similar. The study by van den Brink-Muinen et al. (2000), which investigates communication in different gender dyads, reports no clear relationship between question use and culture either.

In my analysis and comparison of questions in intercultural and Swedish medical consultations, I will also address the issues of power, gender and culture in medical consultation and will compare my results to the results of the studies mentioned above in subsection 5.1.6.

5.1.2 Some comments about coding and data analysis

In my analysis, I will primarily rely on CA research. I distinguish between single-unit questioning turns and multi-unit questioning turns. In the SUQT category, that is, turns that consist of one utterance, I include yes/no questions, wh-questions, fill-in-the-blank questions, declaratives, phrases as questions and disjunctive questions. In addition, questions used with particles are included in this category (though they are not considered as a separate question type). The MUQTs are of two types. The first consists of one or more statements followed by one or more questions. The second is represented by a turn that consists of two or more questions with different kinds of relations.

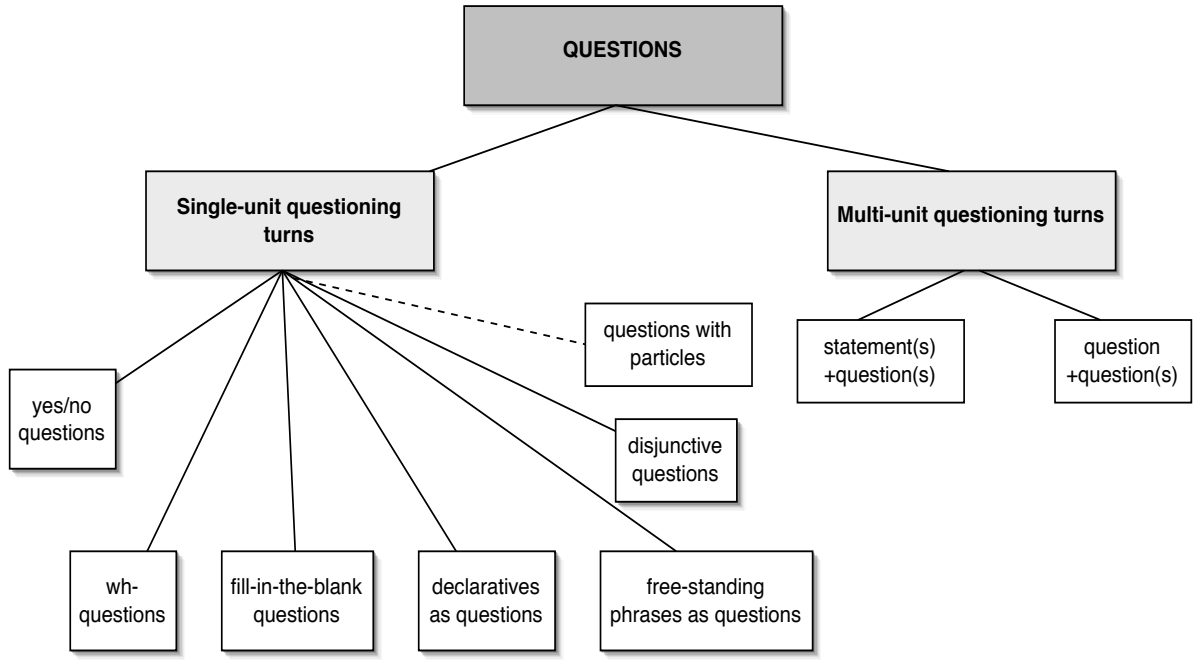

Figure 4: Types of questions

The questions were coded by using the transcriptions of the recordings and listening to and watching the recorded audio/video interactions. After finishing the coding, I verified the material; ambiguous cases were discussed and resolved with a second, independent analyst.

The study of questions in medical consultations is presented below. First, a qualitative analysis of single- and multi-unit questioning turns used in the recorded medical consultations between the non-Swedish physicians and their Swedish patients and the Swedish physicians and their patients is provided. Then, a quantitative analysis is presented, in which the frequencies of use of different question types are presented and discussed. The analysis is done in relationship to gender and cultural group (Hungarian, Iranian, Mixed and Swedish groups). The differences were checked for statistical significance using $\chi 2$ tests.

5.1.3 Single-unit questioning turns (SUQTs): Qualitative analysis of question types

5.1.3.1 Yes/no questions

Yes/no questions are commonly introduced by a finite verb and are used to ask for specific information, expecting an answer of yes or no. However, as Lindholm (2003) points out, an expanded response to a yes/no question is not uncommon, that is, one that includes not only minimal response words (feedback)[23], as exemplified below:

Example 21. "Eyeglasses" (IraD9)

The physician and the patient are talking about the patient's eyesight

Speaker	Transcription	Translation into English
$D:	**har du glasögon**	***do you have eyeglasses***
$P:	ja de har ja med mig	*yes I have them with me*

To the physicians' question about eyeglasses, the patients provides an answer consisting of a feedback word *ja* ('yeah') and additional information *ja de har ja med mig* ('yes, I have them with me'). Conversely, in example 22 below, the response provided by the patient contains a feedback word only:

Example 22. "Children" (IraD6)

The physician is talking about the patient's family situation including the death of his wife

Speaker	Transcription	Translation into English
$D:	**har ni barn**	***do you have children***
$P:	nej	*no*
$D:	nej < /// > e å e du ensam nu eller	*no < /// > er and are you alone now or*
@ < hand gesture: writes in her notepad >		

In response to the physician's question regarding children, the patient provides a negative answer, which is sufficient for the physician, who is filling in the file. This might be due first of all to the question's sensitive nature and the patient's being unwilling to discuss it in detail.

23. In the thesis, I use the term "feedback" instead of Lindholm's "minimal response" for the same phenomenon.

It might also be because the doctor is filling in the form. In some cases, the feedback words are also omitted by the answerer (in the example below, it is the patient):

Example 23. "P-pills" (HuD1)

The physician is inquiring about what medication the patient uses

Speaker	Transcription	Translation into English
$D:	**å äter < dy > nåra mediciner**	***and do < you > take any medication***
@ <SO: du/you >		
$P:	< p > piller	*contraceptive pills*
@ < letter >		

The patient provides the name of the pills instead of giving a positive/negative response. This may be motivated by the patient's expectation that the physician will be interested in getting the information rather than simply a positive or negative answer.

According to Lindholm (2003) and Ainsworth-Vaughn (1998), yes/no questions are the most common question type used by physicians.

In my corpora, the patients use yes/no questions primarily for asking about instructions before examination, for example, *ska ja ta av mej den* ('shall I take it off?'), *ska jag sätta mig upp* ('shall I sit up?'), and asking about treatment, as in *ska ja ta det* ('shall I take it?').

5.1.3.2 Wh-questions

Questions introduced with an interrogative pronoun or adverb, such as *vem* ('who'), *var* ('where'), *hur* ('how'), etc., are known as wh-questions and allow a wide range of responses. As I mentioned above, these questions can be "open" to a greater or lesser extent (i.e., requiring more or less specific information). Consider the example below in which an Iranian physician asks her patient a question concerning her job:

Example 24. "What do you do?" (IraD7)

The physician is inquiring about the patient's background

Speaker	Transcription	Translation into English
$D:	**va jobbar du me**	***what do you do***
$P:	ja studerar // ja läser interaktionsdesign ute på < IT > universitetet	*I study // I study interaction design at the < IT > university*
@ < abbreviation >		

The information required by the physician is more limited than what is asked for in the example below:

Example 25. "How have you been?" (IraD10)

The physician is inquiring about the patient's state of health since the last consultation

Speaker	Transcription	Translation into English
$D:	jaa ja se: de // ska vi se: // ja: **hur ha de varit paula sedan sist**	*yeah I see: // let's see: //* ***well how have you been paula since last time***
$P:	jo de: e inga problem faktist	*well there are no problems actually*

This question is more open than in the previous example, allowing a wider range of responses from the patient and encouraging more talk.

The patients also use wh-questions to ask about the kind of treatment they will get (*vad ska jag göra* [‘what shall I do?’]) and its length (*hur lång tid räknar ni att de tar en sån här* [‘how long do you estimate it will take, such a?’], *när får ja åka hem* [‘when may I go home?’]), seeking information about the location and causes of symptoms (e.g., about gallstones: *va har ja egentlien i sidan* [‘what do I really have in my side?’], *vad beror de på* [‘what’s the cause?’]), as well as when they do not understand something (*vadå för nåt* [‘what?’], vad sa du [*‘what did you say?’*]). In a few cases, the patient asks about the physician’s background, for example, *hur länge har du varit läkare* (‘how long have you been a doctor?’).

5.1.3.3 Fill-in-the-blank questions

Although few occurrences are observed in the data, fill-in-the-blank questions (*lucklämnande frågor* in Swedish) are worth mentioning here. Fill-in-the-blank questions are defined as “uncompleted utterances of a type that can be regarded as intentionally interrupted in order to appeal to the interlocutor for help to fill in one or more (timely) words” (Linell and Gustavsson, 1987, p. 34; our translation from Swedish). An example of this question type is provided below:

Example 26. “And once” (HuD4)

Talking about different kinds of narcosis

Speaker	Transcription	Translation into English
$D:	m // var de e anestesi eller e nån bedövning	*m // was it er anesthesia or er some injection*
$P:	de va lokalbedövning två gånger	*it was local injection twice*
$D:	< två gånger [lokalbedövning] > **å en gång**	*< twice [local injection] >* ***and once***
@ < head movement: nods >		
$P:	[a]	*[yeah]*
$P:	e ryggmärgsbedövning	*er spinal injection*

5.1.3.4 Declaratives as questions

Questions can also be expressed by means of declaratives, which are sometimes called B-event statements, a concept introduced by Labov and Fanshel (1977) for information that is primarily known to recipient B but not to speaker A. B-statements are treated by interactants as seeking confirmation (or disconfirmation). Consider the example below:

Example 27. “Vegetarian” (IraD10)

The physician is inquiring about the patient’s eating habits

Speaker	Transcription	Translation into English
$D:	**men du äter inte bara vegetarist**	***but you don’t eat vegetarian (food) only***
$P:	nä ja äter e fisk å // kyckling	*no I eat er fish and // chicken*

The physician’s question is about a fact known by the patient and is treated by the interactants as a statement that not only needs confirmation, but also elaboration: the patient states that she eats both fish and chicken.

Although yes/no questions and declarative questions have different forms, they have similar functions. The difference might lie in the declarative questions’ being more directive than

yes/no questions. For example, Lindholm (2003) notes that patients have a tendency to agree with the physician. In addition, the use of declaratives instead of yes/no questions can also indicate a more informal, casual tone of interaction (Pentz, 1996).

5.1.3.5 Free-standing phrases as questions

Free-standing phrases, such as adjective phrases, noun phrases, preposition phrases, verb phrases, etc., can be used with an interrogative function. Lindholm (2003) mentions primarily noun phrases used for questions. Wynn (1995) calls this phenomenon "question lists": providers (primarily) use free-standing phrases while going through a number of questions in a short period of time, in routine or formal tasks, completing a written form, etc. A free-standing noun phrase used as a question is presented below:

Example 28. "Profession" (GerD12)

Physician inquiring about the patient's background

Speaker	Transcription	Translation into English
$D:	**< yrke >**	*< profession >*
@ < gaze: D is looking down and reading from another paper >		
$P:	e vårdarinna	*er nurse*
$D:	< vårdarinna >	*< nurse >*
@ < hand gesture: D is writing >		

In the example above, the physician is filling in the patient's file, specifically the section with the patient's background information such as age, profession, etc. By reading the respective sections of the patient's file, the physician uses the names of the sections as questions.

5.1.3.6 Questions with particles

In the data, there are a number of questions that include all of the above-mentioned question types except fill-in-the-blank, and end with *eller* ('or'), *då* ('then') and *va* ('don't you', 'can't you', 'right'). In addition, a few questions that end with *ja* ('yeah'), *nej/nä* ('no', 'nah'), and *inte* ('not') were found, used primarily by the non-Swedish physicians. This is not a Swedish way of asking questions but is probably a transfer from the non-Swedish physicians' native languages.

Note that, as mentioned above, questions with particles are not different question types but variations on the above-mentioned question types. Below, I provide a brief overview of their functions and use in my data.

Questions with eller ('or')

Questions (yes/no or declaratives) with *eller* ('or') in post-sentential position are the most common type of questions with particles in the material. Lindström (1990) calls them an "or-inquiry," which is defined as a "yes/no question or B-event that ends with the Swedish conjunction *eller*," produced and understood as a turn in its own right (p. 60). In addition, the particle *eller* is designed to be heard as a constitutive component of its host TCU rather than as an add-on post possible completion. There is no pause or hesitation at the syntactic completion point between the penultimate word and *eller*. In my analysis, I follow these criteria. Cases when interruptions occur are excluded. If there is an overlap and the utterance is complete, it is included.

Example 29. "Diet" (SweD3)

Prescription. Talking about diet

Speaker	Transcription	Translation into English
$D:	**vill du hålla diet eller**	***do you want to follow a diet or***
$P:	ja försöker	*I will try*

The excerpt above exemplifies the use of a yes/no question with *eller*; by the physician requests information on whether the patient wants to follow a diet. By using *eller*, the question points to possible alternatives.

An example of a patient using a question with *eller* is provided below:

Example 30. "Back to Hungary or" (HuD3P7)

The patient is asking if the Hungarian physician is planning to go back to Hungary

Speaker	Transcription	Translation into English
$P:	**e så du ska tillbaks till ungern sedan eller**	***er so you will go back to hungary later or***
$D:	e de är en intressant fråga	*er that's an interesting question*

As above, the patient uses the declarative + *eller* to allow an alternative answer from the physician.

To summarize, the function of questions with *eller* is basically similar to the functions of yes/ no and declarative questions. However, the use of eller in post-sentential position means that the question allows for an alternative. It is probably a more careful, less direct and less encroaching way of asking questions.

Questions with då ('then')

According to Eriksson (1988), the particle *då* ('then') used after a question marks the anticipated disapproval of some possible answers to the question (p. 106). In her analysis of *då* in questions used by physicians, Lindholm (2003) cites Hakulinen and Saari (1998) as saying that questions with *då* typically function as *fortsättningsfrågor* ('continuation questions') (p. 131) when the speaker wants more information about something previously discussed in the interaction.

The example below illustrates the use of *då* by a patient:

Example 31. "Take tests now" (SweD4P49)

Talking about taking a blood sample

Speaker	Transcription	Translation into English
$D:	du // va de gäller din mage så tycker vi väl att vi har e: / löst problemet nu	*well // about your stomach I guess we consider that we have er / solved the problem now*
$P:	aså ja	*really yeah*
$D:	men visst / har vi tat < blodprovena redan eller >	*but I think / we've already taken the < blood tests haven't we >*
@ < gaze: looking at the nurse >		
$N:	näh [1 han får ta de nu]1	*no [1 he can take it now]1*
$P:	**[1 ja men ja fick inte]1 gjort de / får ja gå å ta de efteråt [2 nu då]2**	***[1 yes but I did not]1 get it done / I'll go and take it afterwards [2 now then]2***

$D:	[2 ja]2 // visst vi ska göra de efteråt nu	*[2 yes]2 // sure we'll do it afterwards now*

Here, the patient hears what the nurse and the physician are saying about him having a test. He summarizes what they have said and asks if he can take the test now.

A question with the particle *då* may also mark the connection to what was said earlier in the interaction and introduce something new (*inference marker*; Lindström, 1990). However, I did not find any such examples in my data.

Questions with va ('don't you', 'can't you', 'right')

Few occurrences of questions ending with *va*, translated into English as the tag 'can't/don't you?', are observed in the data. Eriksson (1988) cites Andersson (1976) as stating that *va* can have two functions: either the speaker wants the listener to verify what has been said or the speaker is checking to find out whether the listener has followed and understood what is being said. Consider the example below:

Example 32. "You want to" (IraD8)

The physician and patient are discussing the wait time for surgery

Speaker	Transcription	Translation into English
$D:	ja tror inte att du ska gå flera månader	*I don't think that you'll wait several months*
$P:	nä för då åker ja utomlands vet du å fixar de	*no because then I'll go abroad and fix it you know*
$D:	jo de e klart att du kan göra va du vill **va** [de kan du]	*well yeah of course you can do whatever you want **right** [you can]*
$P:	[ja ja visst] de gör ja ju för att ja (...) inte en chans	*[yeah of course] I do that you know because I don't (...) have a chance*
$D:	**du vill bli opererad direkt va**	***you want to have surgery immediately don't you***
$P:	ja (...) 1att e ja har värk hela tiden // ja känner mej som en halv karl ja kan inte lyfta nånting	*yeah (...) that er I'm in constant pain // I feel like half a man I can't lift anything*

In this example, the physician uses *va* ('don't you?') to invite the patient to verify what he says about the planned treatment.

Questions with ja ('yes'), nej ('no'), nä ('nah') and inte ('not')

Few occurrences of questions with the particles *ja/nej/nä* ('yes'/'no'/'nah') or the adverb *inte* ('not') are observed in the corpora. The questions with the above-mentioned particles typically govern the interlocutor's response; for example, questions with *ja* ('yes') seek confirmation from the interlocutor:

Example 33. "Hurts now, yes?" (IraD9)

The physician is examining the patient's eye

Speaker	Transcription	Translation into English
$D:	nej de // om du kan va [snäll å] sätta hakan // **svider nu ja**	*no it // could you [please] put your chin // **hurts now yes***
$P:	[ja]	*[yes]*
$P:	ja ja ska bara blinka till lite så där	*yes just let me blink a little like that*

Here, the Iranian physician asks (judging from the questioning intonation) the patient whether his eye hurts and the patient confirms it. *Ja* is used as an eliciting particle, which is

uncommon in Swedish and might be a transfer from the physician's native language.

5.1.3.7 Disjunctive questions

Disjunctive (or alternative) questions present alternative states of things and require information about which of them is true (Teleman et al., 1999, vol. 1, p. 153[24]). The alternatives are connected by *eller* ('or'). Lindholm (2003) defines disjunctive questions as consisting of nominal or adverbial phrases connected with *eller*:

Consider the example below in which adverbial phrases are used:

Example 34. "Weight" (SweD1)

Talking about weight

Speaker	Transcription	Translation into English
$D:	**aa / ha du gått upp eller ner i vikt**	***well / have you gained or lost weight***
$P:	de ä samma	*it's the same*

However, when the units connected with *eller* are full clauses, they are treated as MUQT in Lindholm (2003), for example:

Example 35. "Drops" (IraD9)

Speaker	Transcription	Translation into English
$D:	**har du slutat med dropparna eller har du dropparna**	***did you stop taking the drops or do you have the drops***
$P:	nej ja droppar kvar	*no I have drops left*

In the example above, the two questions connected with *eller* relate to different things, which is why the turn is called an MUQT. This is discussed in more detail below. It is also interesting to point out that the patient misunderstands the physician's question. What the physician actually is asking is if the patient is still taking the drops, while the patient interprets the question as "do you have any drops left?"

24. In SAG, the expression *alternativ fråga* ('alternative question') is used.

5.1.4 Multi-unit questioning turns (MUQTs): Qualitative analysis of question types

Linell et al. (2003) distinguish two types of MUQTs from a syntactic perspective. The first type comprises the so-called *framing questions* (i.e., MUQTs which include "one or several statements (S) usually before but sometimes after the interrogative unit(s), ('question': (Q)"). The second type of MUQTs "comprise exclusively a sequence of interrogatives (two or more Qs)" (p. 549). Both types are represented in the data and will be discussed in more detail below. I follow Lindholm (2003) in not characterizing as MUQTs those turns which are interrupted by receipt or acknowledgment (feedback) tokens from the interlocutor.

5.1.4.1 MUQTs consisting of statement(s) and question(s) (framing questions)

According to Linell et al. (2003), MUQTs that consist of one or more statements that provide some background to the question(s) that follow(s) are called **framing questions**. Consider the example below:

Example 36. "What medication do you use?" (RusD18)

Talking about medication

Speaker	Transcription	Translation into English
$D:	**ja / vi har inte pratat om e mediciner dina mediciner vilka mediciner använder du**	***yeah / we haven't talked about er medication your medication what medication do you use***
$P:	e [de]	*er [it]*
$D:	[vilka] mediciner står du på	*[what] medication are you on*

The MUQT consists of a statement (*vi har inte pratat om e mediciner dina mediciner* ['we haven't talked about er medication your medication']) followed by a wh-question about the medication the patient is taking. Here, the statement provides the introduction to the question.

5.1.4.2 MUQTs consisting of questions

The types of MUQTs that consist of several questions differ on the basis of the type of relationship between the questions.

The most common kind is the so-called **question cascade** (Clayman and Heritage, 2002, as cited in Linell et al., 2003), where the relationship between the questions is **a particularizing (specifying) one** (i.e., each following question is a specification of the preceding one, defining a more narrowly based query). It is exemplified by the excerpt below:

Example 37. "Pain in the arm" (HuD3)

Inquiring about the pain in the patient's arm after surgery

Speaker	Transcription	Translation into English
$D:	**har < dy > / ONT nånstans / har du ont e: i armen fortfarande**	***does it HURT somewhere / does your arm still hurt***
@ < SO: du/you >		
$P:	ja'a	*yeah*
@ < abbreviation >		

Here, the physician first asks if the patient feels pain somewhere. The more general question (*har dy ONT nånstans* ['does it HURT somewhere?' (literally: 'have you PAIN

somewhere?')]) is followed by the more specific one (*har du ont e i armen fortfarande* ['does your arm still hurt?' (Literally: 'have you pain in the arm still?')]). This is the most frequent MUQT type in the data produced by the physicians. However, only one occurrence of this type is produced by a patient (the patient inquires about her future treatment and asks the physician about what will happen to her: *va händer då får jag medicin då* ['what happens then, will I get medication then?']).

Another kind of MUQT consisting of a number of questions is the so-called **question paraphrase** (Linell et al., 2003), in which two or more questions in a sequence are variants of the same question (i.e., the same question is presented in different words, for example, using a more colloquial style instead of formal language). However, the authors point out that the boundary between MUQTs with a specifying relationship between the component questions and MUQTs that include question paraphrases is far from clear-cut. In my data, the non-Swedish physicians are observed using question paraphrases often, due to their language problems, to ensure that their patients understand:

Example 38. "How did you get?" (HuD3)

History taking. Inquiring about the origin of symptoms

Speaker	Transcription	Translation into English
$D:	**mhm mhm okej okej // e hur fick du dom här <1 smär+ >1 e dom här såren då // hur blev <2 så här >2 //**	***mhm mhm okay okay // er how did you get these <1 pain+ >1 er these wounds then // how did it become <2 like this >2 //***
@ <1 cutoff: smärta/pains>1 @ <2 hand gesture: right hand pointing at stomach >2		
$P:	all < pressen menar (du) > ja de va en bra fråga	*all < the pressure > (you) mean > well that's a good question*
@ < hand gesture: right hand on stomach >		

The physician in this case simply repeats the same question because of problems finding the right word.

Yet another type of MUQT consists of **collateral questions**, that is, several questions that appear not to have any relationship to each other (Linell et al., 2003). However, as Linell et al. mention, there is often a "super-topic" that causes the questions to be delivered together. Few examples are present in my data. One of them is presented below:

Example 39. "Symptoms" (HuD3)

The physician is asking the patient about her current condition

Speaker	Transcription	Translation into English
$D:	**e va känner du < 1 här känner du >1 <2 trycket / <3 tjänner >3 du >2 / e: <4 illamåendekänsla >4 / <5 känner du att någonting >5 <6 tar emot att e svälja >6 / ma:t**	*er what do you feel <1 here do you feel >1 <2 the pressure / <3 do you feel >3 >2 / er <4 nauseous >4 / <5 do you feel something >5 <6 hindering er to swallow >6 / foo:d*
@ <1 hand gesture: with left hand >1 @ <2 hand gesture: with left hand on his shoulder >2 @ <3 hand gesture: with left hand, SO: känner/feel >3 @ <4 hand gesture: with both hands >4 @ <5 hand gesture: with left hand >5 @ <6 hand gesture: with left hand pointing at his throat >6		
$P:	ja mår inte illa / näeh	*I don't feel sick /nah*

The common topic of all three questions is "symptoms." The physician is inquiring about different kinds of symptoms (pressure in the chest, nausea and problems with swallowing). Another example of this MUQT type is a turn that consists of two questions: *a har du blivit undersökt e me lungröntgen / när va sista gången du har varit undersökt me lungröntgen* ('well, have you had an X-ray examination / when was the last time you were examined?'). One of the questions refers to whether the patient had an X-ray and the second to when it took place.

Collateral questions can also be connected with *eller* ('or'), for example:

Example 40. "Up a little bit" (SweD9)

Talking about the patient's work

Speaker	Transcription	Translation into English
$D:	**känner du dej i skick att orka söka jobb som du känner dej NU eller måste du först upp en bit**	***do you feel well enough to search for a job the way you feel NOW or do you need to get up a bit first***
$P:	ja måste upp en bit	*I need to get up a bit*

Here, the two questions connected with *eller* ('or') present two alternatives, which are related by a common topic: the patient's job search.

The opposite to the particularizing type of question mentioned above are the so-called **generalizing appended questions** (Q + eller + Q +...), which broaden rather than narrow the range of possible answers (Linell et al., 2003). Consider the example below:

Example 41. "Taking blood tests" (SweD3)

The physician is inquiring about the patient's blood tests

Speaker	Transcription	Translation into English
$D:	**va de HÄR dom tog de eller var de**	***was it HERE they took them or was it***
$P:	tog blodprovena här ja	*took the blood tests here yeah*

Here, the second element in the turn extends the possible response range. Lindholm (2003) comments on the incompleteness of the second component in discussing whether it is treated as a TCU or not. I would state that, in the majority of cases, if there is no interruption that prevents the speaker from completing the utterance, this incompleteness has a generalizing function.

5.1.4.3 Unclear cases

In a few cases, it was difficult to decide what kind of turn a question constituted. One of them is the example below:

Example 42. "Cold all the time" (IraD7)

The physician is inquiring about the patient's state of health since the last consultation

Speaker	Transcription	Translation into English
$D:	men e ja skulle bara fråga en / ställa en annan fråga till dej / har du varit / frisk under den e / senaste tiden / ja menar när du e förkyld har du varit < hel+ > hela tiden förkyld eller / du har varit frisk en två dagar å sen /	*but er I was just going to ask you one / ask you another question / have you been / well er / lately / I mean when you have a cold have you had the cold < a+> all the time or / you have been well for one two days and then /*
@ < cutoff: hela/all >		

$P:	jag har känt mej halvdåli men / men ja har tränat ändå / å så har de < blitt > värre	*I have felt partly bad (literally: half bad) / but I've taken exercise anyway / and then I got worse*
@ < SO: blivit/got >		

Here, from one perspective, the physician's turn, which is introduced by a metastatement or "preliminary," can be coded as one that includes a more general question followed by a specifying question. However, it can also be seen as an example of paraphrase.

5.1.5 Quantitative analysis of question types

In this section, I will present quantitative results concerning the use of questions by the physicians and their patients in both corpora. I will start with an overview of the data on SUQTs, followed by an overview of the data on MUQTs. $\chi 2$ tests were used to test the significance of differences.

5.1.5.1 Single-unit questioning turns (SUQTs)

General overview

I start with an overview of the total number of SUQTs, namely simple questions produced by non-Swedish physicians, Swedish physicians and their respective patients. As the sizes of corpora differ, in order to be able to compare the use of questions, I calculated the percentage of each question type in relation to the number of utterances produced by the physicians/ patients. The utterances were counted using *Tal-till-tal* (Hartzell and Mäkk, 2003).

Table 48: SUQTs: overview. Percentage of questions out of total number of utterances

	Non-Swedish physicians	Swedish physicians	Patients of non-Swedish physicians	Patients of Swedish physicians
Total number of utterances	3875	2867	4056	2945
Total number of SUQTs	810	491	129	85
% of SUQTs	21%	17%	3%	3%

The table shows that the **physicians** use considerably more questions than the patients in both intercultural and Swedish-only medical consultations. The differences are statistically significant (the difference between the non-Swedish physicians and their patients: $\chi 2 = 596.33$ [df = 1], $p < .001$; and between the Swedish physicians and their Swedish patients: $\chi 2 = 329.94$ [df = 1], $p < .001$). This is not surprising, as in a medical consultation it is the physician who asks questions in order to get information about the patient so he/she can make a diagnosis and prescribe suitable treatment.

Comparing **the non-Swedish and Swedish physicians,** the non-Swedish physicians asked more questions than the Swedish physicians ($\chi 2 = 15.09$ [df = 1], $p < .001$). This can be explained by the fact that ICCMedConsult contains more consultations and more consultation types than SweMedConsult.

Comparing the **patients** of non-Swedish and Swedish physicians, it can be observed that the percentage of simple questions is similar (3%)[25]. Thus, there seems to be no difference in the

25. I present the $\chi 2$ values only when there is a significant difference.

number of questions asked by patients in intercultural and Swedish medical consultations.

We shall now turn to the distribution of different question types in the corpora. In Table 49, I present the percentage of each question type out of the total number of questions, for the physicians and patients.

Table 49: SUQTs: distribution of different question types (in absolute numbers and percentage of total questions)

Number of occurrences per question type/ percentage of question type	Yes/no	Wh	Declarative	Phrasal	Disjunctive	Fill-in-the-blank	Questions with particles			
							eller	*då*	*va*	*ja/nej/ nä/inte*
Non-Swedish physicians										
	234 29%	169 21%	102 13%	142 17%	38 5%	14 2%	89 11%	7 1%	4 0.5%	11 1%
810										
Swedish physicians										
	176 36%	67 14%	97 20%	56 11%	11 2%	5 1%	38 8%	36 7%	1 0.2%	4 0.8%
491										
Patients of non-Swedish physicians										
	26 20%	39 30%	20 15%	11 9%	3 3%	1 1%	8 6%	20 16%	1 1%	0 0%
129										
Patients of Swedish physicians										
	26 31%	17 20%	21 25%	4 5%	2 2%	0 0%	9 11%	5 6%	1 1%	0 0%
85										
*The numbers do not add up to 100% because of rounding.										

Yes/no questions are the most common question type for the **physicians**, representing 29% of the simple questions used by the non-Swedish and 36% by the Swedish physicians.

No statistically significant differences are observed in the frequencies of yes/no, declarative and fill-in-the-blank questions between the non-Swedish and Swedish physicians. Too few occurrences of questions with the particles *va, ja/nej/nä* and *då* were found in the data to draw any conclusions concerning differences between the groups of physicians.

The non-Swedish physicians use wh-questions, questions with *eller*, phrases as questions and disjunctive questions more than the Swedish physicians.

Statistically significant differences were observed between the non-Swedish and Swedish physicians in their frequencies of use of wh-questions ($\chi 2 = 19.99$ [df = 1], $p < .001$), questions with *eller* ($\chi 2 = 8.42$ [df = 1], $p < .01$), phrases as questions $\chi 2 = 16.93$ [df = 1], $p < .001$) and disjunctive questions ($\chi 2 = 8.15$ [df = 1], $p < .01$).

The Swedish physicians use somewhat more questions with *då* than the non-Swedish physicians, though no statistically significant difference is observed.

Concerning the **patients**, too few occurrences of the patients asking the physicians questions exist in the data to draw any conclusions.

The fact that more wh-questions are observed in the speech of the non-Swedish physicians might stem from a number of factors. One possible explanation is the difference in consultation types included in the ICCMedConsult and SweMedConsult corpora. Consultations in the field of anesthesiology, gynecology, ophthalmology, rehabilitation, intensive care, orthopedics, general practice, and surgery are represented in ICCMedConsult while only general practice and surgery consultations are included in SweMedConsult. This aspect might result in more question types being produced by the physicians in general, and more wh-questions in particular. Wh-questions are primarily used in history taking. The larger number of consultations and variety of types and, consequently, the fact that there are more instances of history taking might result in the higher number of wh-questions in the ICCMedConsult corpus.

Another tentative explanation for the greater use of wh-questions by the non-Swedish physicians can be illustrated by the following excerpt from a consultation. A Hungarian physician comments to the patient that it is very important to take the patient's history:

```
$D: e: min överläkare frågade mej att e e göra en e / anamnes och de e jätteviktit
att få en bra anamnes från patienten
```
$D: er: my senior physician asked me to er er take er / anamnesis and it is awfully important to get a good anamnesis from the patient.

Being new in their workplace and attempting to do their best might result in the non-Swedish physicians' being particularly thorough when collecting information from their patients (the non-Swedish physicians' meticulousness was reported by the patients, see section 4.6 above). As wh-questions from the physicians limit the patients' responses less than yes-no questions and declaratives, their more intensive use by the non-Swedish physicians might be a consequence of their striving to give their patients more options for responses because they want as much information as possible from them. (One should bear in mind that though wh-questions vary in their "degree of openness," as shown, they still allow a greater response range than "closed-ended questions.")

Questions with *eller* are used more by the non-Swedish than by the Swedish physicians. As I mentioned above, the use of *eller* with closed-ended questions can point to possible alternative answers. It might also reflect a less encroaching way of asking questions.

Concerning the non-Swedish physicians' more intensive use of phrases as questions, I presume that language competence might play a role here; using phrases for questions is easier for a non-native speaker than formulating syntactically complete questions. Furthermore, the use of the patient's file as a support is another tentative explanation of the greater frequency of this question type in the non-Swedish physicians' speech. The same is true of questions with *då*. The fact that the non-Swedish physicians did not adopt this strategy might depend upon language competence, among other things. In addition, this question type is less important in this activity than other types (e.g., wh- and yes/no questions), which is another possible explanation.

In addition, the individual questioning behavior of physicians may also play a role in the cases above.

To summarize, activity influence and participants' roles explain why the physicians ask more questions than the patients in both intercultural and Swedish medical consultations. Concerning similarities between

the participants, yes/no questions are the most common type for both non-Swedish and Swedish physicians. No statistically significant differences in the frequencies of yes/no, declarative and fill-in-the-blank questions between the physicians are observed. The non-Swedish physicians use more wh-questions and more questions with eller *than the Swedish physicians, which might be due to individual differences in questioning behavior and to the non-Swedish physicians' extra thoroughness in collecting information from their patients. The non-Swedish physicians use phrases as questions more than the Swedish physicians, which might be due to their language competence (i.e., using phrases for questions is easier for a non-native speaker than using syntactically complete questions). Use of the patient's file as a support is another possible explanation. As for the patients, too few data are available to draw any conclusions concerning the distribution of question types. However, it can be observed that the percentage of questions out of the total number of utterances for the patients is similar for the patients of both non-Swedish and Swedish physicians (3%).*

Gender

Table 50 presents the use of questions in the four gender combinations.

Table 50: SUQTs: gender

Number of occurrences per question type/ percentage of question type	**Yes/no**	**Wh**	**Declarative**	**Phrasal**	**Disjunctive**	**Fill-in-the-blank**	**Questions with particles**				**Total # of questions per gender combination**
							eller	***då***	***va***	***ja/nej/ nä/inte***	
Non-Swedish physicians											
M phs–M pat	85 32%	56 21%	32 12%	39 15%	16 6%	6 2%	14 5%	4 2%	3 1%	8 4%	263*
M phs–Fpat	69 34%	33 16%	20 10%	57 28%	8 4%	7 3%	9 5%	1 1%	0 0%	2 2%	206
F phs–F pat	34 24%	38 26%	16 11%	21 15%	7 12%	0 0%	25 17%	1 1%	1 1%	1 1%	144
F phs–M pat	46 23%	42 21%	34 17%	25 13%	7 4%	1 1%	41 21%	1 1%	0 0%	0 0%	197
Swedish physicians											
M phs–M pat	50 42%	21 18%	22 19%	10 8%	0 0%	1 1%	2 2%	12 10%	0 0%	2 2%	120
M phs–Fpat	88 41%	23 11%	30 14%	27 13%	4 2%	3 1%	19 9%	21 10%	1 0.5%	0 0%	216
F phs–F pat	33 24%	20 15%	42 31%	15 11%	5 4%	1 1%	16 18%	2 2%	0 0%	2 2%	136
F phs–M pat	5 26%	3 16%	3 16%	4 21%	2 10%	0 0%	1 5%	1 5%	0 0%	0 0%	19
*The numbers do not add up to 100% because of rounding.											

It is difficult to draw any conclusions from the table above, as it is questionable whether there are enough data. The disjunctive and fill-in-the-blanks questions and those with *då*, *va, ja/ nej/nä*, and *inte* are represented by too few instances. However, tentative observations can be made concerning the other question types. They are presented below.

The male non-Swedish physicians use more yes/no questions when talking to their male patients (M phs–M pat) than are observed in the consultations between female non-Swedish physicians and their female patients (F phs–F pat), $\chi 2 = 9.4$ (df = 1), $p < .01$. No

significant differences between the same-sex combinations are observed for the Swedish physicians. The use of this question type by physicians in cross-sex encounters (M phs–F pat and F phs–M pat) shows no significant differences for either the non-Swedish or Swedish physicians.

Looking at the use of wh-questions, no statistically significant differences can be observed between M phs–M pat and F phs–F pat for non-Swedish or Swedish physicians. The same is true of declarative questions. However, the male non-Swedish physicians use wh-questions and declaratives less when talking to female patients (M phs–F pat) than female non-Swedish physicians talking to male patients (F phs–M pat) ($\chi 2 = 16.310$ [df = 1], $p < .001$ and $\chi 2 = 20.26$ [df = 1], $p < .001$, respectively). No significant differences were found between Swedish physicians in the cross-sex encounters.

Concerning phrasal questions, no significant differences were found between the same- and cross-sex consultations for physicians in both corpora.

Another interesting observation is that **female non-Swedish and Swedish physicians talking to female patients (F phs–F pat) use questions with *eller* more than male non-Swedish and Swedish physicians talking to male patients (M phs–M pat).** The differences are significant (non-Swedish physicians: $\chi 2 = 7.9$ [df = 1], $p < .01$; Swedish physicians: $\chi 2 = 10.79$ [df = 1], $p < .01$). Moreover, female non-Swedish physicians talking to male patients (F phs–M pat) use more questions with *eller* than male physicians talking to female patients (M phs–F pat)($\chi 2 = 51.839$ [df = 1], $p < .001$). No significant differences were found between the same combinations for Swedish physicians.

To sum up, male non-Swedish physicians talking to male patients use more yes/no questions than female non-Swedish physicians talking to female patients, while no differences are observed for Swedish physicians in the same-sex combinations.

Here, it is possible to assume tentatively that male non-Swedish physicians talking to male Swedish patients use a more "matter-of-fact" style with their yes/no questions than the female physicians talking to female patients; as a result, they obtain precise and to-the-point responses from their male patients. However, as the Swedish male physicians talking to their male patients do not show the same tendency, it is not certain that gender is the influencing factor here.

No significant differences are observed in the use of wh-questions, declarative questions and phrases as questions by physicians in same- and cross-sex combinations in either group, except that male non-Swedish physicians talking to female patients use less wh- and declarative questions than female non-Swedish physicians communicating with female patients.

Again, it is complicated to explain these findings. However, it is possible that, in general, male and female physicians' questioning behavior does not depend on gender.

Both female non-Swedish and female Swedish physicians talking to their female patients use more questions with eller *than male physicians talking to male patients; in addition, female non-Swedish physicians use even more* eller *questions when talking to male patients than when talking to female patients.*

As mentioned above, questions with *eller* allow for an alternative and they constitute a less

direct and possibly more consensus-seeking way of asking questions than yes/no and declarative questions. Thus, the use of questions with *eller* may indicate a more consensus-seeking way in which female physicians talk to their patients?

Cultural groups

Below, I present an overview of question use by physicians in the different cultural groups. As the number of questions for the patients is too small, no comparison is possible.

Table 51: SUQTs: physicians of different cultural groups. Number of occurrences (in absolute numbers) and percentage of each question type out of total number of questions

Number of occurrences per question type/ percentage of question type	**Yes/no**	**Wh**	**Declarative**	**Phrasal**	**Disjunctive**	**Fill-in-the-blank**	**Questions with particles**				**Total # of questions**
							eller	***då***	***va***	***ja/nej/ nä/inte***	
Hungarian physicians											
	88 36%	45 19%	22 9%	30 12%	20 8%	7 3%	30 12%	1 1%	0 0%	0 0%	243*
Iranian physicians											
	100 26%	80 21%	55 14%	73 19%	12 3%	1 0.3%	47 12%	4 1%	4 1%	7 2%	383
Mixed group physicians											
	46 25%	44 24%	25 14%	39 21%	6 3%	6 3%	12 6%	2 1%	0 0%	4 2%	184
*The numbers do not add up to 100% because of rounding											

I do not have enough evidence to form any definite conclusions concerning the relationship between the physicians' cultural backgrounds and their use of questions. The distribution of question types is similar in all three cultural groups (i.e., yes/no questions are the most common, followed by wh-, phrasal and declarative questions as well as questions with *eller*). This might indicate that the use of questions is more influenced by activity, gender and language acquisition than by cultural/linguistic background, which supports the few previous studies on the relationship between questioning behavior and culture (Ohtaki et al., 2003; van den Brink-Muinen et al., 2000).

5.1.5.2 Multi-unit questioning turns (MUQTs)

General overview

In this section, I present a general overview of the use of MUQTs by the participants in intercultural and Swedish-only medical consultations. As with the overview of SUQTs, provided above, I will start with a general overview of MUQTs:

Table 52: MUQTs: overview. Percentage of questions out of total number of utterances

	Non-Swedish physicians	**Swedish physicians**	**Patients of non-Swedish physicians**	**Patients of Swedish physicians**
Total number of utterances	3875	2867	4056	2945
Total number of MUQTs	100	61	0	7
% of MUQTs	3%	2%	0%	0.2%

The table shows that MUQTs represent 2% to 3% of the total number of utterances in the speech of the physicians in the two corpora. Few occurrences of MUQTs were found in the patients' speech. This is similar to what Lindholm (2003) observed in her data (i.e., the physicians use more MUQTs than their patients). No statistically significant differences in the number of MUQTs can be observed between the non-Swedish and the Swedish physicians

Table 53: MUQTs: distribution of different types in relation to the total number of MUQTs (in absolute numbers and percentage of total questions)

	MUQTs S+Q/ Q+S Framing questions	**MUQTs Q+Q** ***Types of MUQTs with regard to relation between component questions of MUQTs***						**MUQTs S+Q/ Q+S** Framing questions	**MUQTs Q+Q** ***Types of MUQTs with regard to relation between component questions of MUQTs***		
		Specifying	Paraphrases	Collateral	Generalizing appended	Unclear cases			Specifying	Paraphrases	Collateral
Non-Swedish physicians							**Patients of non-Swedish physicians**				
Total:	12 12%	50 50%	17 17%	17 17%	3 3%	1 1%	**Total:**	0 0%	0 0%	0 0%	0 0%
100							**0**				
Swedish physicians							**Patients of Swedish physicians**				
Total:	8 13%	25 41%	6 10%	15 24%	6 10%	1 2%	**Total:**	4 58%	1 14%	1 14%	1 14%
61							**7**				

To start with the **physicians**, there are no striking differences in the distribution of different types of MUQTs between the non-Swedish and Swedish physicians. However, I would like to note that MUQTs with a specifying relationship between the component questions and question paraphrase MUQTs are somewhat more common for the non-Swedish physicians (specifying 50% and paraphrases 17% in the non-Swedish physicians' speech and 41% and 10% in the Swedish physicians' speech), although no statistically significant differences in the frequencies between the native and non-native physicians are observed. I presume that the more intensive use of the above-mentioned MUQT types by the non-Swedish physicians may be linked to their language issues, as they attempt to make themselves understood and to be as clear as possible. It is not uncommon for native speakers to find that non-natives repeat

what they have already said.

The fact that the **patients** prefer the statement + question (S+Q) type is not surprising and has already been mentioned by Lindholm (2003).

Gender

Concerning gender, the numbers are too small to draw definite conclusions, so I will simply present some observations.

Table 54: MUQTs: gender

	MUQT S+Q/Q+S	**MUQT Q+Q**					**Total per gender combination**
		Types of MUQTs with regard to relation between component questions of MUQTs					
	Framing questions	Specifying	Paraphrases	Collateral	Generalizing appended	Unclear cases	
Non-Swedish physicians							
M phs–M pat	6 18%	14 41%	6 18%	7 21%	1 3%	0 0%	34*
M phs–Fpat	4 17%	10 42%	3 13%	6 24%	1 4%	0 0%	24
F phs–F pat	1 6%	10 60%	3 18%	2 12%	0 0%	1 6%	17*
F phs–M pat	1 4%	16 64%	5 20%	2 8%	1 4%	0 0%	25
Swedish physicians							
M phs–M pat	3 21%	2 14%	2 14%	4 28%	3 21%	0 0%	14
M phs–Fpat	2 10%	9 43%	3 15%	4 19%	3 15%	0 0%	21*
F phs–F pat	3 14%	11 50%	1 5%	7 32%	0 0%	0 0%	22*
F phs–M pat	0 0%	3 75%	0 0%	0 0%	0 0%	1 25%	4
*The numbers do not add up to 100% because of rounding.							

It is interesting that consultations in which MUQTs include a statement primarily involve male **physicians** (10 out of 11 occurrences for the non-Swedish physicians and 5 out of 8 for the Swedish physicians). Again, although I avoid drawing any definite conclusions, male physicians seem to show a tendency to use more S+Q/Q+S type MUQTs than female physicians. Possibly, males are more likely than females to provide grounds for their questions.

Cultural groups

The data on the different cultural groups are presented in Table 55.

Table 55: MUQTs: physicians of different cultural groups. Number of occurrences (in absolute numbers) and percentage of each question type out of total number of questions

	MUQTs S+Q/Q+S Framing questions	**MUQTs Q+Q**					**Total number of questions**
		Types of MUQTs with regard to relation between component questions of MUQTs					
		Specifying	Paraphrases	Collateral	Generalizing appended	Unclear cases	
Hungarian physicians	5 11%	20 44%	8 18%	10 22%	2 4%	0 0%	45 100%*
Iranian physicians	4 13%	19 62%	4 13%	3 10%	0 0%	1 3%	31 100%*
Physicians in the Mixed group	3 13%	11 46%	5 21%	4 17%	1 4%	0 0%	24 100%*
*The numbers do not add up to 100% because of rounding.							

The Hungarian physicians use more MUQTs than the Iranian physicians ($\chi 2 = 7.07$ [df = 1], $p < .01$) or the physicians from the Mixed group ($\chi 2 = 10.57$ [df = 1], $p < .01$). The Hungarian physicians are the ones who had spent the least time in Sweden, so this might be an indication that physicians with the least language skills use MUQTs more, in order to ensure that their questions are clear and explicit.

5.1.6 Results, discussion and conclusions on information seeking

To summarize the results presented above, I have analyzed and compared how questions are asked by non-Swedish and Swedish physicians and by their patients. Although I attempted to use a questionnaire to find out whether the patients think there are differences between non-Swedish and Swedish physicians, this study was primarily based on an analysis of recorded medical consultations.

The data analysis shows that there are both similarities and differences in questioning behavior between non-Swedish and Swedish physicians and their patients.

To start with the **similarities**: both the non-Swedish and Swedish physicians ask more questions than their patients, which can be explained by the influence of activity and has already been mentioned in earlier research (e.g., Ainsworth-Vaughn, 1998; Lindholm, 2003). However, no difference in the number of questions asked by patients in the ICCMedConsult and SweMedConsult corpora can be observed; in other words, I have no evidence that Swedish patients ask more questions when communicating with Swedish physicians than with non-Swedish physicians.

Thus, the patients of the Swedish physicians appear not to be more active questioners than the patients of the non-Swedish physicians, from which it can be concluded that the fact that a physician is a non-native speaker and a representative of a culture different from the patient's might not influence a patient's questioning behavior.

The findings of this study also support previous research in showing that yes/no questions are the most common type used by physicians (Ainsworth-Vaughn, 1998; Lindholm, 2003) and that framing questions are common in the speech of patients (Lindholm, 2003). In general, I have observed that both Swedish and non-Swedish physicians use the same question types. Moreover, no significant differences in distribution of such "simple question" (SUQT) types as yes/no, declarative, and fill-in-the-blank, or of MUQTs, are observed between the non-Swedish and Swedish physicians. Unfortunately, some question types were used to a very limited extent (e.g., disjunctive questions, questions with *då*), which prevents one from drawing any conclusions about their frequency of use.

As I have mentioned, more intensive use of so-called closed-ended questions (which commonly include declaratives, yes/no questions, and tag-questions; see, for example, Gnisci and Bonaiuto, 2003) by the physicians often indicates greater physician dominance while the use of so-called open-ended questions (wh-questions) is considered a sign of the physician giving the patient more space for comments and results in more patient involvement and, therefore, a more egalitarian relationship between the two participants.

Although I have pointed out that this view of the relationship between power and questioning behavior is over-simplified, the results of this study do not show that there are differences in the frequencies of use of yes/no and declarative questions (too few occurrences of disjunctive questions are represented in the data), indicating that the non-Swedish physicians do not exhibit more dominant questioning behavior than the Swedish physicians.

Concerning **differences**, a tentative explanation for the more frequent use of wh-questions by the non-Swedish than the Swedish physicians might be that the non-Swedish physicians are new in the workplace and attempting to do their best in, among other things, collecting information from patients, which might result in their being more thorough in asking questions.

The **language acquisition factor** is a tentative explanation of the fact that the non-Swedish physicians use more phrases as questions in talking to their patients than the Swedish physicians do. The use of phrases instead of syntactically complete questions might be a result of problems formulating messages as well as of using the patient's file as a support tool, as pointed out by Wynn (1998). If we return to the comments provided in the questionnaire, the patients commented that the non-Swedish physicians asked shorter questions. Probably the intensive use of phrasal questions by the non-Swedish physicians is the reason for these comments.

The level of language competence might also account for the fact that the non-Swedish physicians ask few questions with *då* (complexity of use). MUQTs with a specifying relationship between the component questions and ones that include the question-paraphrases are more common for the non-Swedish than the Swedish physicians, which may be linked to the non-native physicians' attempts to be as clear as possible in a language they have not fully mastered. The fact that the Hungarian physicians use more MUQT than the physicians from Iran and the Mixed group might indicate that the physicians with the least language competence use MUQTs more, in the hope of being clearer and more explicit.

Concerning **gender**, questions with *eller* are used more by female physicians, which might reflect a more consensus-seeking way of asking questions. Though I have also observed other

tendencies, such as the male non-Swedish physicians' using more yes/no questions in talking to male patients than the female non-Swedish physicians use in communicating with female patients, it is difficult to draw any definite conclusions.

In addition, such factors as the physicians' individual questioning behavior may also have an impact in these cases. As for the patients, they asked few questions, which makes it complicated to draw any conclusions concerning the question types they used.

5.2 Information giving in intercultural and monocultural medical consultations: analysis of the use of the indefinite pronoun *man* ('one')

How much information the physician should give to the patient, what kind of information to give and how it should be conveyed are influenced by a number of factors. According to Hippocrates, physicians are responsible for deciding how much information is in the patient's interests (Hippocrates, 1923, cited in Waitzkin, 1985, p. 81). A number of studies show that the amount of information given to the patients varies depending upon such factors as the nature of the disease, which implies a higher or lower level of confidentiality or disclosure, and the patient's education, age, and cultural background.

In an overview of the research in the area of information giving, Waitzkin (1985) mentions class differences as one of the factors that influence how much patients ask their physicians and how much information the physicians provide; patients from lower social classes receive less information than patients from higher social classes (see also Willems et al., 2005). Setting also has an impact: private-practice patients often expect to get more information from their physicians than patients at a hospital outpatient department (Waitzkin, 1985). Gender and cultural differences are other factors (e.g., Street, 2002).

In medical consultation, it is the physician who possesses specialized medical knowledge, regardless of the patient's educational level in other areas; as a result, the physician controls the information process and the patient depends on the information the physician delivers. The physician's ability to provide information to the patient is essential. The fact that a physician is a foreigner and has a different linguistic and cultural background from the patient, which is the focus in this thesis, might have an impact on the information providing in medical consultations. Patient anxiety about the physician's ability to provide information might be a negative consequence.

I have already presented some observations on the non-Swedish and Swedish physicians' giving information to their patients, which show that patients are generally satisfied with their communication and the amount of explanations provided by non-Swedish physicians (see 4.2).

In analyzing the recorded interactions, an interesting difference in how non-Swedish and Swedish physicians provide information to their Swedish patients can be observed. This difference concerns the use of the indefinite pronoun *man*, which is similar to English *one*, French *on*, Spanish *uno* and German *man* (Altenberg, 2005). This pronoun is used much more often in the discourse of Swedish physicians than in that of non-Swedish physicians.

Man is used to express a general statement and avoid specification. According to SAG (Teleman et al., 1999), *man* is used in utterances about people in general (generic selection of multitude, in which the speaker is included), when the speaker intends to show that what is said is valid for anyone, including himself/herself. *Man* is also used to refer to any person who belongs to the textually or situationally given multitude of referents (specific selection in which the speaker does not need to be included). In addition, *man* is used in cases when the speaker cannot or is unwilling to specify the referent for certain reasons (e.g., confidential information). It can also be used if a speaker to avoid being subjective in his/her statement.

Liebscher (2006) emphasizes that the use of *man* "places less responsibility on the speaker in explicitly formulating a perspective" (p. 164). Similarly, Altenberg (2005) points to the impersonal effect of the use of *man*, which results in the speaker placing her/herself at a distance from what he/she says. Although the referent is sometimes vague, it is often possible from the context of the interaction determine what referent is meant.

Medical consultation as a social activity generally involves two participants, the physician and the patient. The talk during consultation is usually related to issues that concern the patient, a concrete referent. When physicians use the impersonal generic pronoun in interaction with their patients, this might result in a more general, "distanced" and consequently more neutral kind of behavior; it is a sign of the physician's taking a less encroaching position in relation to the patient and giving the patient more freedom. As the aim of this thesis is to analyze physician-patient communication and the relationship between the participants in intercultural and Swedish-only medical encounters, one might presume that Swedish physicians' more intensive use of *man* may indicate their more distanced and less personal way of talking to patients, compared to the non-Swedish physicians. This might reflect a different communicative style. This could be an interesting cultural factor. The use of *man* in the sequences in which the physician is providing information to the patient (e.g., concerning the choice of treatment, giving advice) may be a sign of their more indirect way of influencing the patient, more "neutral" persuasion and, consequently, a more distanced, less personal relationship. In addition, it can indicate power differences. It may also be a consequence of the fact that the use of this pronoun is not emphasized in Swedish language teaching.

5.2.1 Some comments about coding and data analysis

For the study, the instances when physicians used the indefinite pronoun *man* in sequences in which they provided information to their patients have been selected. As with the coding of questions (section 5.1.2), the coding was done both by using the transcriptions of the recordings of medical consultations and by listening to and watching the recorded consultations. The ambiguous cases were discussed and resolved with an independent analyst.

The referent types for use of *man* were identified. The interpretation of *man* depends upon whether the physician is talking about himself/herself or about the patient. The determinants are the predicate, the context and the activity. Below, an overview of different uses of *man* by Swedish and non-Swedish physicians in medical consultations is presented.

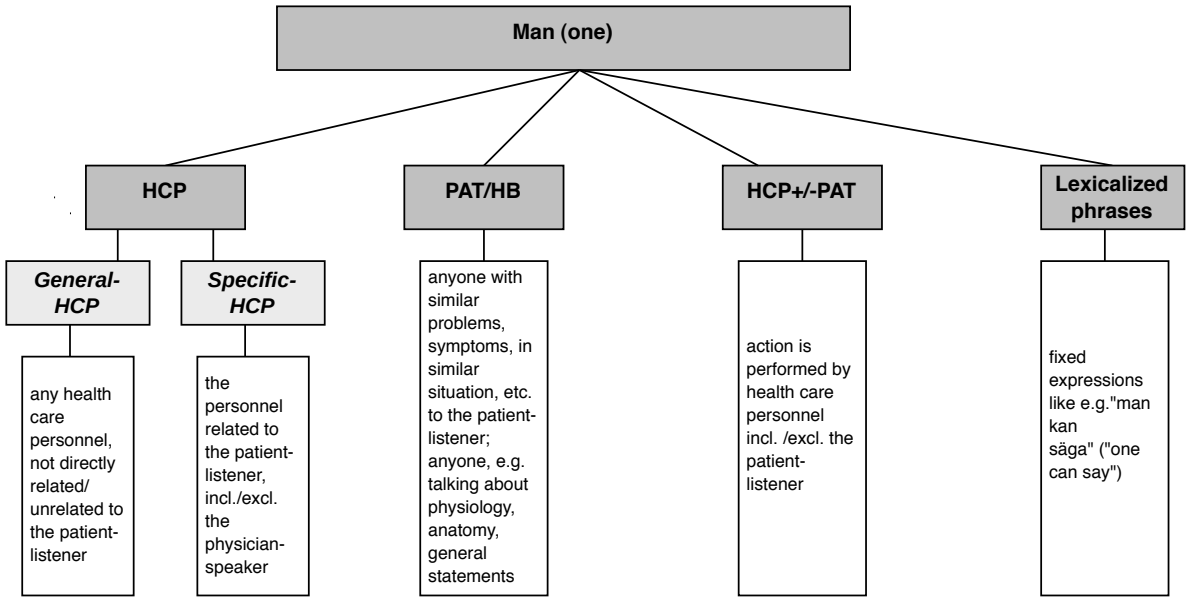

Figure 5: Use of *man* ('one') in medical consultations

The physicians, both Swedish and non-Swedish, use *man* to refer to health care personnel (HCP) in general (General-HCP) or specific people who are involved in the patient-listener's treatment (Specific-HCP), to the patient or human beings in general (PAT/HB), to health care personnel including or excluding the patient (HCP +/-PAT), as well as in lexicalized phrases. Below, a detailed analysis, explanations and examples for each type are presented.

5.2.2 Qualitative analysis of use of *man* in medical consultations

5.2.2.1 Referring to "Health Care Personnel" (HCP)

The physicians often use *man* to refer to health care personnel. Two main types of referent can be distinguished. The first type is when the physician refers to health care personnel in general, who are not involved or, more specifically, not *directly* involved in the patient-listener's case (General-HCP). This use can be observed in sequences when the physicians are talking, for example, about research, developments in medical treatment, etc. The example below illustrates this use:

Example 43. "Keyhole surgery" (SweD7)

The physician and patient are discussing the upcoming surgery. The physician provides the patient with some background information regarding keyhole surgery (laparoscopy)

Speaker	Transcription	Translation into English
$D:	de e väl så att **man** e //just nu befinner sej i e // de **man** har väl hållit på å operera me titthålsteknik dom sista ja tiefemton tjugo åren ja e inte säker / å då har de blivit praxis att man opererar gallblåsor me titthålsteknik	*I guess that **one** er // just now finds oneself in er // it **one** has performed surgery with keyhole technology for the last well ten fifteen twenty years I think I'm not sure / so it has become practice to perform keyhole surgery on gallbladders*

The physician provides a general background on the use of laparoscopy in practice. In this

case, *man* refers to the people involved in the research (General-HCP), who have no direct relationship with the patient-listener.

A more common case in the data is, naturally, when the physician-speaker is referring to the personnel related to the patient-listener (Specific-HCP), that is, those who have provided, will provide or are currently providing care for the patient-listener. Consider the example below:

Example 44. "The gallbladder looked strange" (SweD7)

History taking. The physician talks about the patient's treatment in the emergency ward

Speaker	Transcription	Translation into English
$D:	någon gång när du låg inne på avdelningen under hösten så såg **man** att de såg lite konstit ut på gallblåsan som om du hade en inflammation där // du hade också ont i magen	*once when you were admitted at the ward this autumn **one** noticed that the gallbladder looked somewhat strange as if you had an inflammation there // you had stomach pain as well*

By using *man*, the physician is referring to the specific health care provider(s) who did the analysis of the patient's gallbladder. It is worth mentioning here that it is often problematic to judge from the context whether the physician-speaker is including himself/herself in the specific-HCP referent (as in the example above) or not. In the example below, the referent apparently excludes the physician-speaker. This can be determined from the context (i.e., the physician states that he got the referral from a colleague and is now meeting the patient for the first time):

Example 45. "The eyesight will not be better" (IraD9)

History taking. Talking about a referral from a colleague

Speaker	Transcription	Translation into English
$D:	ja har tittat här e på papprena vi har fått en remiss från en kollega här att e du har åldersförändringar i gula fläcken och e du har även gråstarr också	*I have looked here er at the papers we've received a referral from a colleague here that er you have macula changes due to old age and er you also have cataract as well*
$P:	m	*m*
$D:	yeah	*yeah*
$P:	ja har de ja	*I do yeah*
$D:	m	*m*
$P:	ja ser så dåligt så usch (...)	*my vision is so poor ugh (...)*
$D:	ja // då har **man** pratat me dej att de / gula fläcken e så mycke // skadad att	*right // so **one** has talked to you that it / your macula is so much // damaged that*

The physician uses *man* to refer to the health care personnel who had previously told the patient about the situation with her eye.

In the example below, a Hungarian physician and his Swedish patient are talking during the physical examination. By using *man*, the physician refers primarily to himself, probably in order to be less subjective:

Example 46. "Good heart and good lungs" (HuD4)

The physician is examining the patient's heart and lungs prior to anesthesia

Speaker	Transcription	Translation into English
$D:	< ta djupa andetag /// andas in /// > mycke fina hjärtljud och / [helt klart]	*< take deep breaths /// breathe in /// > very good heart beats and / [all clear]*
@ < event: examining P's heart and lungs with a stethoscope >		
$P:	[m]	*[m]*
$P:	okej //	*okay //*
$D:	andningsljud också	*breathing sounds too*
$P:	m	*m*
$D:	**man** hör ingenting // ingen nån e / blåsljud på hjärtat eller nån / ronki eller rassel i lungorna	***one** hear nothing // no any e /heart murmur or any / rattling or wheezing in your lungs*

The physician says *man hör ingenting* ('one hears nothing') while listening to the patient's lungs and heart. The physician's action helps the hearer to understand the referent for *man* (the physician-speaker).

5.2.2.2 Referring to "Patient" (PAT) / "Human Beings" (HB)

Telling the patient about the causes of his/her disease, the nature of the symptoms and possible treatments is an important part of medical consultation and one of the obligations a physician has in a medical consultation as a social activity. While doing this, physicians often need to speak in both specific and general terms to describe such issues as, for example, health problems, symptoms, etc. that are common to anyone in the same situation as the patient-listener. This is exemplified by the excerpt from an interaction between a Swedish physician and her patient presented below, in which the physician attempts to explain to the patient why her hiatus hernia is occurring:

Example 47. "One can have trouble with hernia" (SweD7)

The physician is talking about problems with hernia

Speaker	Transcription	Translation into English
$P:	här <1 [1 aså >1 // m]1 där har ja ont många gånger <2 alltså just här >2 <3 / >3 men < 4 så försvinner de >4 men de kommer igen	*here <1 [1 you know >1 // m]1 it often hurts there <2 right here see >2 <3 / >3 but <4 then it disappears >4 but it keeps coming back*
@ <1 hand gesture: points with right hand to her chest >1 @ <2 hand gesture: points with right hand to her chest >2 @ <3 head movement: D nods >3 @ <4 hand gesture: with both hands >4		
$D:	[1 ja // precis]1 men **man** kan ha besvär / av bråck för de gör ju att e / de ser inte riktit ut som vanlit [2 de vill säja]2 / i vanlia fall så sluter ju övre magmunnen tätt < så de kan försvinna e mat å dryck å sånt neråt >	*[1 yeah // exactly]1 but **one** can have trouble / with hernia because it makes it / not really look as usual [2 that is]2 / normally the upper opening of the stomach fits tightly < so food and drink and such can pass down >*
@ <hand gesture: with both hands up and down >		
$P:	[2 ja]2	*[2 yeah]2*
$D:	men de ska inte kunna komma uppåt igen förutom när **man** kräks	*but it shouldn't be able to come upwards again apart from when **one** vomits*

$P:	ja'a	*yeah*
@ < head movement: nods >		
$D:	men e har **man** ett bråck då står <1 de ju lite mer öppet där >1 å då kan <2 surt innehåll från magen spola upp i matstrupen >2 <3 å de gör ont >3	*but er if **one** has a hernia then <1 it's somewhat more open there you know >1 and then <2 acid stomach content may flush up into the gullet >2 <3 and that hurts >3*
@<1 hand gesture: with both hands >1 @<2 hand gesture: with right hand upwards >2 @<3 head movement: nods >3		

By using *man*, the physician gives a general explanation of the negative effects of hernia, which are common to anyone with this problem, including the patient-listener, but with less intrusion into the patient's personal space.

Man is often used in sequences in which the physicians make recommendations to their patients. Consider the example below from an interaction between a Swedish physician and his patient:

Example 48. "Sedative" (SweD2)

Prescription. The physician is talking about anxiety treatment

Speaker	Transcription	Translation into English
$D:	de finns inga medel som gör att **du** / **man** tar de varje kväll å så sover **man** gott å **man** vaknar pigg å glad de ä inte så	*there are no remedies that can make **you** / **one** takes it every night and then **one** sleeps well and **one** wakes up fit and happy that's not how it is*

In answering the patient's question, the Swedish physician can be observed changing from *du* ('you') to *man* in order to provide a more general answer to the patient's question. It makes the recommendation more neutral and less categorical. In addition, the use of *man* opens up the possibility that this particular patient might be an exception.

The example below is quite interesting for intercultural communication study. A Swedish female physician and her female patient are discussing the possibility of the patient's having surgery. The patient disagrees and provides a number of arguments concerning why she considers the surgery to be unnecessary at the time (e.g., not experiencing many problems with ostomy, being too old, having had too many surgeries already, unwillingness, etc.). The physician's reaction is presented below:

Example 49. "One may express one's opinion" (SweD7)

Talking about a possible surgery

Speaker	Transcription	Translation into English
$D:	då har ja inget mer å tillägga // de viktia e att **man** får va me å bestämma å att **man** får uttrycka sin åsikt	*then I have nothing else to add // the important thing is that **one** may take part in the decision and that **one** may express one's opinion*

This example shows the Swedish physician' using *man* to refer to her patients, including the patient-listener, who may be involved in the decision-making process. Apart from exemplifying the use of *man* for generalizations, this example reflects the physician's view of the patient's role in decision-making, the importance of the patient's involvement; according to Herlitz (2003), this is common in Sweden.

An interesting difference between the Swedish and non-Swedish physicians' ways of making recommendations can be observed by comparing the way the Swedish physician makes a

recommendation in example 49 above with the one below made by an Iranian physician (as well as Example 18):

Example 50. "Be careful with it" (IraD6)

The physician is talking to the patient about the negative consequences of sitting too long in a wheelchair

Speaker	Transcription	Translation into English
$D:	du e lite röd i baken också // [1 här]1	*your behind is slightly red as well // [1 here]1*
$P:	[1 ja]1 aha	*[1 yeah]1 I see*
$D:	de har varit tidigare också // eller // de [2 e lite röd här]2 // **var försiktig me den**	*it has been previously as well // or // it's [2 slightly red here]2 //* ***be careful with it***
$P:	[2 a / a]2 precis	*[2 yeah / yeah]2 exactly*

Because she is worried that the red spot may be a pressure sore, the Iranian physician strongly advises her patient to be careful about it. This way of making recommendations is more direct than in the previous example or the example below from a Swedish physician:

Example 51. "One must go out and get exercise" (SweD2)

Talking about the importance of physical activity

Speaker	Transcription	Translation into English
$D:	de vill säja **man** måste försöka å / som medicin gå ut å röra på **sej** / å blir de så (...) där får **man** öva sej	*that is* ***one*** *must try to / as medication go out and get exercise / and in that case (...) there* ***one*** *may practice*

This recommendation, like the one in Example 49, is given in a more general way than the Iranian physician's recommendation. The modal verb *måste* ('must') used with the impersonal pronoun is a way of giving a direct strong recommendation, but the use of the impersonal pronoun makes it more neutral and indirect and less encroaching.

Man is also used when the physician delivers information that may be perceived as sensitive, as in the example below, in which a German physician is talking to his forty-two-year-old female patient who has just had a baby and has experienced complications after the delivery:

Example 52. "One is not that young" (GerD12)

Talking about complications after delivery

Speaker	Transcription	Translation into English
$D:	speciell inte så ung kvinnor // [1 de]1 blir sån chock // på kroppen	*special not that young women / [1 it's]1 such a shock // on the body*
$P:	[1 precis]1	*[1 exactly]1*
$P:	ja ja	*yeah yeah*
$D:	(...) graviditet [2 alltså]2	*(...) pregnancy [2 that is]2*
$P:	[2 ja]2 ja	*[2 yeah]2 yeah*
$D:	men <1 förti >1 eller <2 förtiett >2 är sent // å därför **man** är mycke gammal	*but <1 forty >1 or <2 forty-one >2 is late // and that is why* ***one*** *is very old*
@ <1 SO: fyrtio/forty >1 @ <2 SO: fyrtioett/forty-one >2		

By using *man*, the physician makes the message about the patient's age (*man är mycke gammal* ['one is very old']) sound more neutral, more general, less offensive and less

confrontational.

In some cases, *man* refers to any human being, when the physician is talking about general health issues (e.g., anatomy, physiology) that are not directly related or not related at all to the patient's experiences. Consider the example below in which the physician is talking to a patient who has pain in her ear because of a loud noise:

Example 53. "Hearing" (SweD6)

Speaker	Transcription	Translation into English
$D:	fast du kan ju va försiktig me å / men de gäller alla / ungdomar och alla människor måste va försiktia me att utsätta sej för för starka ljud **man** ska va rädd om sin hörsel	*but you know you can be careful with / but that's valid for all / teenagers and everybody have to be careful with exposing themselves to loud sounds **one** should look after one's hearing*

Here, the physician points out that anyone and everyone should be careful about their hearing. However, it is often problematic to clearly define borders between "patient" and "human being" from the context; this is why the occurrences of *man* used to refer to the patient and to human beings in general were placed in the same category.

To summarize, the physicians use man *to provide more general explanations and more neutral, less encroaching advice to their patients.*

5.2.2.3 Referring to "Health care personnel" and "Patient" / "Health care personnel" or "Patient" (HCP+/-PAT)

Consider the example below:

Example 54. "One can do something else" (SweD1)

Prescription. Discussing the patient's high blood pressure

Speaker	Transcription	Translation into English
$D:	om trycket inte håller sej bra då kan du ta kontakt så kan **man** göra nåt annat	*if the pressure doesn't stay fine you can get in touch so **one (we)** can do something else*

In the example above, from one perspective, *man* refers to "health care personnel," who will provide medical help to the patient in case of problems with blood pressure. From another perspective, the physician says that the patient should come back if problems with blood pressure occur and the health care personnel will help, which can be seen as "you come for help, you will be informed what help you can be provided, and we (health care personnel) will help you." If we interpret it in this way, *man* refers to both the patient and the health care personnel, although the emphasis in this case is primarily on the health care personnel, as they are the ones who can *göra* ('do') something else.

Instances like this were coded as HCP+/-PAT. Example 55 illustrates the difference from the category HCP, in which man refers to "health care personnel" only (discussed above):

Example 55. "One cuts the skin" (SweD5)

Prescription. Talking about the coming surgery

Speaker	Transcription	Translation into English
$D:	de blir ju lite inflammation runt omkring de eftersom **man** skär ju huden å så går **man** in å så sen säger du att de att den har varit lite // e: olika gånger// så så: blir de < li+ >/ som en sårläkning	*it gets somewhat inflamed around it you know since **one** cuts the skin you know and **one** goes in and then you say that it that it has been somewhat // er different times // so so it becomes < so+ > / like a wound healing*
@ < cutoff: lite/somewhat >		

When the action determined by the predicate is done exclusively by a health professional with no involvement by the patient (e.g., descriptions of a surgeon's actions during surgery, as illustrated above), the instance is coded as HCP.

5.2.2.4 Lexicalized phrases

The impersonal pronoun *man* is used in a number of fixed expressions, such as *man kan säga* ('one can say'), *måste man säga* ('one must say'), etc., which are used with no specific reference. In the example below, the patient proudly tells the physician about his exercise program and even "jogging" in the spring marathon after his surgery:

Example 56. "That's strong" (SweD5)

Talking about the patient's state of health after the consultation

Speaker	Transcription	Translation into English
$P:	ja lunkade vårruset i alla fall [1 (...)]1 eller när de nu va	*I jogged along* vårruset *(jogging festival) at least [1 (...)]1 or whenever it was*
$D:	[1 m men de va ju < strongt >]1	*[1 m that's < strong >]1*
@ < loan English: strong >		
$P:	ja	*yeah*
$P:	så att e // de gjorde ja [2 faktist]2	*well er // I [2 actually]2 did*
$D:	[2 de]2 **måste man ju säga** e ett bra resultat ändå	*[2 why]2 **one must admit** it's a good result though*

Måste man ju säga ('one must admit'; Literally: 'one must say') in the example above is used by the physician to make the statement less categorical and more vague, so that it expresses a general truth. It could easily have been left out. This example is also interesting from cultural perspective, as it shows the patient's eagerness to become fit and strong, which reflects a common opinion in Swedish society of the importance of being active and exercising (Herlitz, 2003; Daun, 1996).

5.2.2.5 Unclear cases

"Unclear cases" include uses of *man* in elliptical utterances, self-interruptions, etc., when it is complicated to figure out the referent.

The distribution of *man* in the sequences in which physicians provide information to their patients and in discussion is presented in the next section.

5.2.3 Quantitative analysis of use of *man* in medical consultations

General overview

Table 56 presents the number of occurrences of *man* produced by the non-Swedish and Swedish physicians. The numbers are given in parts per million (PPM). PPM is determined as follows: number of occurrences of man ÷ number of tokens for participant category x 1,000,000. It is important to note that, though I analyzed the occurrences of *man* only in sequences in which the physicians provided information to their patients, the PPM was calculated based on the total number of tokens produced by the physicians (non-Swedish physicians = 31,037; Swedish physicians = 28,727). The reason for this is that the analyzed occurrences represent the majority of instances of *man* produced by the physicians (188 out of 193 by the non-Swedish and 415 out of 420 by the Swedish physicians). Thus, it is possible to presume that the use of *man* in the analyzed sequences reflects a general pattern of use, which allows one to calculate PPM in the way I did.

Table 56: Number of occurrences of *man* in parts per million (PPM)

Non-Swedish physicians							Swedish physicians						
Category	**HCP**		**PAT/ HB**	**HCP+/- PAT**	**Lexicalized phrases**	**Unclear cases**	**Category**	**HCP**		**PAT/ HB**	**HCP+/- PAT**	**Lexicalized phrases**	**Unclear cases**
	Gen.	**Spec.**						**Gen.**	**Spec.**				
	774	1127						1427	1741				
	1901		2191	808	773	384		3168		8459	1532	1010	277
Total:	**6057**						**14446**						

The $\chi 2$ test was used to verify the significance of differences between the Swedish and non-Swedish physicians.

Comparing the **physicians**, the table shows that Swedish physicians use *man* more often than non-Swedish physicians (14,446 vs. 6,057, $\chi 2 = 105.11$ [df = 1], $p < .001$). Statistically significant differences were been observed in the frequencies of *man* in such categories as PAT/HB (8,459 vs. 2,191, $\chi 2 = 113.22$ [df = 1], $p < .001$), HCP (3,168 vs. 1,901, $\chi 2 = 9.56$ [df = 1], $p < .01$)) and HCP+/-PAT (1,532 vs. 808, $\chi 2 = 6.81$ [df = 1], $p < .01$). No significant difference was observed for lexicalized expressions.

The data indicate that Swedish physicians use man *more often than non-Swedish physicians when referring to the patients, personnel and both together while providing explanations to their patients.*

The Swedish physicians' intensive use of the impersonal generic pronoun might be a phenomenon that reflects the Swedish way of talking, which is characterized by indirectness, avoidance of pointing someone out (Sw. *peka ut*) and a rather distanced way of communicating in an attempt to be more objective.

In medical consultation as a social activity, this use of *man* by physicians might be a factor that contributes to a less authoritarian, more mutual type of relationship between physician and patient. The way the physicians function as "advisor" rather than "authority" is reflected in how they talk in more general terms with their patients, along the lines of "I give you

information, but you do as you want" (Sw. *du gör som du vill*) and in Swedish hesitance about imposing on another person's space.

Although the difference in frequency of use of *man* is obvious, there are also some similarities between the Swedish and non-Swedish physicians.

Patient/human being (PAT/HB) is the most common referent for both non-Swedish and Swedish physicians, followed by health care personnel (HCP) as referent and HCP+/-PAT. I would explain these similarities by the influence of the activity. The physician often needs to talk in general terms, pointing out that the patient's problems are not specific to him/her but can affect anyone. Similarly, the need to talk about personnel who have been involved in the patient's treatment (Specific-HCP) and/or have done something related (though distantly) to the patient's case (General-HCP) motivates the use of *man*. The former, however, is more common, as it is the patient's situation that is the focus of the consultation. Using *man* to refer to the patient and/or health care personnel (HCP+/-PAT) may be motivated by a need to express a shared responsibility for the treatment, on the part of both patient and personnel. It means "you (patient) know/allow us to do it and we do it (the treatment, surgery, etc.)".

Gender

Concerning **gender**, the number of occurrences per type for physicians in the four gender combinations (i.e., M phs–M pat, M phs–F pat, F phs–F pat and F phs–M pat) is presented below.

Table 57: Gender: number of occurrences of *man* in PPM[26]

	Non-Swedish physicians							Swedish physicians						
Gender combination (Phs-Pat) /Category	**HCP**		**PAT/ HB**	**HCP+/ -PAT**	**Lexicalized phrases**	**Unclear cases**	**Total per gender combination**	**HCP**		**PAT/ HB**	**HCP+/ -PAT**	**Lexicalized phrases**	**Unclear cases**	**Total per gender combination**
	Gen.	**Spec.**						**Gen.**	**Spec.**					
M phs–M pat	766	1628	2107	670	766	384	**6321**	543	950	4479	814	543	406	**7737**
M phs–Fpat	410	1334	1641	821	718	308	**5232**	647	863	8087	2264	1074	431	**13370**
F phs–F pat	1275	159	1753	319	797	479	**4782**	995	2431	9614	1216	1437	111	**15803**
F phs–M pat	873	873	4147	1746	873	436	**8948**	7596	3963	15852	1982	661	0	**30053**

No clear tendencies concerning gender can be observed in the data; one might also question whether the amount of data allows one to draw definite conclusions. However, an interesting similarity can be observed between the Swedish and the non-Swedish physicians. Female physicians who are talking to male patients (F phs–M pat gender combination) use *man* to refer to PAT/HB more than other gender combinations in both corpora. The differences are

26. PPM is determined as follows: number of occurrences of *man* ÷ number of tokens for physicians in each gender combination (non-Swedish physicians: M phs–M pat = 10,439, M phs–F pat = 9,746, F phs–F pat = 6,272, F phs–M pat = 4,580; Swedish physicians: M phs–M pat = 7,369, M phs–F pat = 9,277, F phs–F pat = 9,051, F phs–M pat = 3,030) x 1,000,000.

significant (non-Swedish physicians: F phs–M pat vs. M phs–M pat, $\chi 2 = 4.8699$ [df = 1], $p < .05$, F phs–M pat vs. M phs–F pat, $\chi 2 = 8.03$ [df = 1], $p < .01$, F phs–M pat vs. F phs–F pat, $\chi 2 = 5.52$ [df = 1], $p < .05$; Swedish physicians: F phs–M pat vs. M phs–M pat, $\chi 2 = 35.88$ [df = 1], $p < .001$, F phs–M pat vs. M phs–F pat, $\chi 2 = 13.889$ [df = 1], $p < .001$, F phs–M pat vs. F phs–F pat, $\chi 2 = 7.97$ [df = 1], $p < .01$). Is this a sign of the female physicians' being more distant and less direct in interacting with the male patients, compared to female patients and male physicians? It is difficult to explain this from the data.

Cultural groups

Concerning the use of *man* by the non-Swedish physicians in the different cultural groups, the data are presented in the Table 58 below.

Table 58: Cultural groups: number of occurrences of *man* in PPM[27]

	Hungarian physicians					Iranian physicians					Mixed group physicians				
Participant category/ type	HCP	PAT/ HB	HCP+ /-PAT	Lexicalized phrases	Unclear cases	HCP	PAT/ HB	HCP+ /-PAT	Lexicalized phrases	Unclear cases	HCP	PAT/ HB	HCP+ /-PAT	Lexicalized phrases	Unclear cases
Total per category	533	1922	107	535	0	3052	3382	1650	825	411	1779	942	418	942	732
Total:	**3097**					**9320**					**4813**				

The Iranian physicians use *man* most, followed by the physicians from the Mixed group and the Hungarian physicians. Statistically significant differences are observed between the Hungarian and Iranian physicians ($\chi 2 = 31.169$ [df = 1], $p < .001$) and between the physicians from the Mixed group and the Iranian physicians ($\chi 2 = 14.92$ [df = 1], $p < .001$). A tentative explanation is that the Iranian physicians have spent more time in Sweden than the Hungarians and most of the Mixed group physicians. The use of *man* requires language competence, which physicians who are relatively new in Sweden might not possess.

One can also consider the influence of the physicians' native languages on the use of *man*. This is reflected, for example, in the German and Colombian physicians' higher use of *man* compared to the physicians from Russia and the former Yugoslavia.

27. PPM is determined as follows: number of occurrences of *man* ÷ number of tokens for the participant category (Hungarian physicians = 9,352; Iranian physicians = 12,112, Mixed group physicians = 9,573) x 1,000,000.

Table 59: Use of *man* by physicians from the Mixed group in PPM[28]

	HCP	PAT/HB	PAT+/-HCP	Lexicalized expressions	Unclear cases
GerD12	2010	1005	603	804	1005
ColD16	2341	2341	781	781	781
RusD19	762	381	0	1143	0
YuD20	0	0	0	1477	1477

In Russian, there is no impersonal pronoun corresponding to Swedish *man*; this might be reflected in the Russian physician's using *man* primarily in lexicalized expressions, which might be learned in chunks, rather than to refer to someone specifically. The same is true of the physician from the former Yugoslavia.

5.2.4 Results, discussion and conclusions on information giving

The comparative analysis of the use of *man* by non-Swedish and Swedish physicians reveals the following:

The impersonal pronoun man *is used more by Swedish physicians than by non-Swedish physicians in sequences in which the physicians give information to their patients. It is used to refer to the patient or human beings in general, to health care personnel, as well as to health care personnel and/or the patient. It may indicate that Swedish physicians adopt a more neutral, less direct way of talking than non-Swedish ones. This may be related to such factors as culture (Swedish indirect style); language acquisition (reflected, for example, in the Hungarian physicians and the physicians from the Mixed group [who had spent less time in Sweden]) using* man *less than the physicians in the Iranian group); and the influence of the non-Swedish physicians' native languages. The fact that the most common referent for* man *is PAT/HB for both Swedish and non-Swedish physicians is a result of the influence of activity (i.e., the patient's situation is the focus, which requires one to use* man *primarily for this referent).*

An interesting observation can also be made concerning the physicians' use of *man* to refer to "Patient and health care provider/Health care provider." This use reflects the ambiguity of the way the physicians talk to patients and how they create the feeling of involving the patient.

Another aspect this study reveals is the impact of the social activity on the analysis of the reference of the impersonal generic pronoun. The social activity of medical consultation with its relatively restricted area of topics and potential referents, makes it relatively simple to clarify the referent, as the interaction is localized around three possible referents: the patient, the personnel (including or excluding the physician), and the physician and patient together.

28. PPM is determined as follows: number of occurrences of *man* ÷ number of tokens for each participant (GerD12 = 4,676; ColD16 = 1,296, RusD19 = 2,624, YuD20 = 677) x 1,000,000.

5.3 Information acknowledgment and checking in intercultural and monocultural medical consultations: analysis of repetitions and reformulations as a type of feedback

In medical consultation, mutual understanding, that is, understanding which refers to both the patient's and the physician's knowledge about each other's opinions (Kleinman, 1980, as cited in Meeuwesen et al., 2007), between physician and patient is important for the quality of health care. Showing that one has understood what the interlocutor said and checking to make sure one understood it correctly are important for both physician and patient. However, it is especially important for the physician, as in a medical consultation it is the physician who is mainly responsible for the interaction due to his/her obligation to make a diagnosis and a decision about a suitable treatment (although the patient might be involved to a higher or lower degree). At the same time, one should not underestimate the need for the patient to demonstrate his/her listening and understanding to the physician as well.

In our case, when consultation is intercultural and involves a non-native physician and a native patient, showing understanding and checking the information provided by the interlocutor are even more important than in monocultural consultations, as problems with understanding can occur due to the physician's language problems and cultural differences. Furthermore, the fact that Swedish patients may be uncertain about the non-Swedish physicians' understanding might result in such feelings as anxiety and fear, which have a negative impact on the consultation process and outcomes. Returning to the Swedish patients' responses to the question on the questionnaire (Q.25) about whether the non-Swedish physicians' language competence influenced their impression of them, such alternatives as "ability to understand me" and "ability to make me feel secure" have the highest response frequencies (43% and 29%, respectively); this indicates that the Swedish patients do feel uncertainty concerning understanding, as well as a lack of security in consultation with the non-Swedish physicians.

Here, the question arises: How do the non-Swedish physicians demonstrate their understanding to the patients? How do they make sure they have correctly understood what their patients are saying? Are there any differences between Swedish and non-Swedish physicians?

Verbal feedback is a way to acknowledge understanding and check the information provided. Feedback is defined by Allwood (1993a) as "linguistic mechanisms which ensure that a set of basic requirements on communication, such as possibilities for continued contact, for mutual perception and for mutual understanding can be met" (p. 1). Structurally, Allwood categorizes feedback (FB) into *simple feedback units* (which consist of one word), subdivided into primary, namely words and morphemes that are almost exclusively used for NFB (feedback in the narrow sense) such as *yeah* and *mm*; and *secondary FB units* such as adjectives, adverbs, conjunctions, pronouns, verbs and nouns, which may be used for feedback purposes, but which have other important functions in the language as well (examples include *good*, *certainly*, etc.). Other categories comprise reduplications of simple FB units such as *yeah yeah*; deictic and anaphoric linking (often by reformulating preceding

utterances), such as English *I do*, *it is*, Swedish *de e de*, *de gör ja*; idiomatic phrases such as *thank you very much*; and modal phrases such *as I think so*.

Allwood (1988, 1993a) defines two primary FB functions: *FBG* (feedback giving or "pure feedback") and *FBG/FBE* (feedback giving and elicitation).

FBG is used to indicate that one is listening to and understanding what the interlocutor says and to express attitude, for example, (dis)agreement, emotion, etc. The FBG/FBE function stands for both showing listening and understanding and checking whether one has heard and understood what the interlocutor said by eliciting a response in the form of confirmation or additional specification. Although in my coding (see 5.3.2. below) I make a distinction between FBG and FBG/FBE, it is worth mentioning here that the term "feedback elicitation" might be misleading, as the evocative function of any contribution, namely eliciting a response (not necessarily in feedback form) is present not only in FBG/FBE but in FBG as well, though to a lesser degree (Allwood, 2007b).

When I analyzed the recordings of medical consultations, I observed an interesting difference between the Swedish and non-Swedish physicians. The latter use a special kind of feedback, namely repetitions and reformulations of (parts of) their patients' utterances, so-called echo-backchannels (Sugito et al., 2000), allo-repetitions (Tannen, 1989), interactive repetitions/ reformulations (Martinovsky, 2001) or other-repetitions (Long, 1981; Svennevig, 2004) more than the former. The structure of the repeated segment varies from exact repetitions of what has been said to paraphrases in which the same meaning is presented in different words. Martinovsky (2001), following Allwood (1988, 1993a), distinguishes between interactive repetitions and interactive reformulations:

> **Interactive repetition** A segment of speech Y in an utterance β by speaker B is an interactive repetition if it is fully identical to a segment of speech X in an utterance α of speaker A where α precedes β, where Y and X are not completely overlapping, and where the criteria of identity consist of a combination of lexicon, syntax and mood (but not necessarily intonation)
>
> **Interactive reformulation** A segment of speech Y in an utterance β by speaker B is an interactive reformulation if it is partially identical to a segment of speech X in an utterance α of speaker A where α precedes β, where Y and X are not completely overlapping, and where the criteria of identity consist of a combination of lexicon, syntax and mood (but not necessarily intonation)
>
> (Martinovsky, 2001, p. 98)

In this section of the thesis, I will specifically focus on the analysis of interactive repetitions and reformulations used for feedback purposes in the intercultural and Swedish medical consultations.[29]

29. I will also present a general analysis of verbal feedback in Chapter 6, section 6.5.4

5.3.1 Repetitions and reformulations as a type of feedback

Repetition/reformulation as a conversational phenomenon has been described and analyzed in a number of studies (Long, 1981; Allwood, 1988; Tannen, 1989; Sugito et al., 2000; Martinovsky, 2001; Perrin et al., 2003; Svennevig, 2004). Among the above-mentioned studies, those by Long, Allwood and Svennevig focus on the use of repetitions and reformulations (more specifically interactive and other repetitions and reformulations) in non-native–native speaker interactions.

Tannen (1989) provides an extensive analysis of repetitions and their functions:

> getting or keeping the floor, showing listenership, providing back-channel response, stalling, gearing up to answer or speak, humor or play, savoring and showing appreciation of a good line or a good joke, persuasion, linking one speaker's ideas to another's, ratifying another's contributions (including another's ratification), and including in an interaction a person who did not hear a previous utterance.
>
> (Tannen, 1989, p. 51)

Sugito et al. (2000), in their analysis of Japanese informal conversations, also emphasize that repeating what the other speaker says indicates willingness to interact and involvement in the interaction.

Perrin et al. (2003, p. 1849) present a summary of the functions of repetitions such as a *taking into account function*, "by which a speaker indicates that what was just said by the interlocutor has been heard and interpreted" (corresponds to Allwood's pure FBG function of repetition); *a confirmation request function* (signaling a problem related to some aspect of the interlocutor's talk), "by which a speaker seeks confirmation or a specification of what has just been said by the interlocutor" (corresponds to Allwood's FBG/FBE function); *a positive reply function*, "by which a speaker expresses agreement with the preceding talk of the interlocutor"; and *a negative reply function*, "by which a speaker expresses disagreement with what the interlocutor has just said" (both are subcategories of FBG).

This thesis focuses on interactions in which participants with different cultural and linguistic backgrounds are involved. Svennevig (2004) shows how other-repetitions are used to display the receipt of information (in Allwood's terms, to give feedback) in interactions between native Norwegian clerks and their non-native clients. Svennevig also points to the impact of intonation on the function of repetition, showing that a plain repeat with falling intonation is a display of hearing while a repeat plus a final response particle, *ja* ('yes'), constitutes a claim of understanding. The use of rising intonation can also display emotional stance (surprise or interest) (p. 489). Long (1981) analyzes NS-NNS interactions in arranged activities, including informal conversation, vicarious narrative, giving instructions for two communication games, etc. Unlike Svennevig's study, in which the non-native speakers were in a subordinate position compared to the native speakers, it is unclear what roles the non-native speakers have in Long's study. Both studies show an intensive use of other-repetitions by native speakers in NS-NNS conversations to ensure comprehension. Long also compares NS-NNS and NS-NS conversations, showing that other-repetitions are used more intensively in the former than the latter.

Concerning non-native speakers and their use of repetitions, I have not found any study that focuses on repetitions in situations in which a non-native speaker is in a superior position to a native speaker in a social activity. In Allwood (1988), the majority of the activities involve

non-native speakers in subordinate positions to native speakers. However, unlike Svennevig's and Long's studies, the focus is primarily on the non-native speaker's production of repetitions/reformulations. As Allwood points out, repetitions/reformulations are widely used by language learners as means for feedback giving and elicitation, especially early in acquisition process, since they are "a simple means of feedback giving for the learner who does not have many other means of expression" (p. 277). The use of repetitions/ reformulations is observed to decrease over time; they seem to be replaced by primary FB units. Furthermore, the native speakers in the above-mentioned study produced little repetition compared to the non-native speakers. Allwood also emphasizes that the use of repetitions/reformulations depends upon a number of factors, such as a particular speaker's characteristics, activity type and how common the use of repetitions/reformulations for feedback giving/eliciting is in the speaker's native language. Culture can also be a contributing factor. As Tannen points out:

> for individuals and cultures that value verbosity and wish to avoid silences in casual conversation, repetition is a resource for producing ample talk, both by providing material for talk and by enabling talk through automaticity.
>
> (Tannen, 1989, p. 48).

All the above-mentioned functions of repetitions and reformulations make them both relevant and interesting to investigate in the context of medical consultation in relation to information acknowledgment and information checking. In spite of the apparent scarcity of research on repetitions/reformulations in medical consultations, their positive impact on communication between physician and patient cannot be overestimated. In his book on communication with patients, aimed at medical students, Bendix (1980) emphasizes the importance of repeating the patient's last words (*Upprepa de sista orden*); among other things, this strategy can encourage the patient to become more open, help to make the issues discussed clearer, and keep both participants interested. All of these outcomes are essential for this activity and the quality of care. In addition, it might be interesting to see how non-native speakers in a superior position over native speakers use this type of feedback to ensure understanding, as well as the possible influence of culture.

5.3.2 Some comments about coding and data analysis

In my coding, I distinguish between repetitions and reformulations, according to Martinovsky (2001). However, I will only briefly comment on what kinds of changes were made in the original utterances.

The repetitions/reformulations are divided into those used for feedback giving (FBG) and those used for both feedback giving and eliciting (FBG/FBE).

FBG and FBG/FBE are distinguished as follows. Repetitions/reformulations that do not evoke confirmation from the interlocutor in the next utterance are coded as FBG while those that evoke such confirmation are coded as FBG/FBE. In addition, in the case of repetitions/ reformulations for FBG, falling intonation is used (similar to Svennevig's study). When the repeated/reformulated segment is used with interrogative (rising) intonation, it is coded as FBG/FBE. When intonation is interrogative, it encourages the production of feedback from the interlocutor. However, the absence of interrogative intonation does not rule out the production of feedback in the next utterance. Therefore, sequences in which the repeated element is followed by confirmation from another speaker constitute a primary criterion for

distinguishing between FBG and FBG/FBE.

In this thesis, the repetitions and reformulations produced by the non-Swedish and Swedish physicians and their respective patients were extracted from the transcriptions and analyzed. Repetitions by other participants, if present, are not considered (e.g., accompanying persons, nurses). All the repetitions and reformulations are grouped on the basis of their function into FBG and FBG/FBE categories.

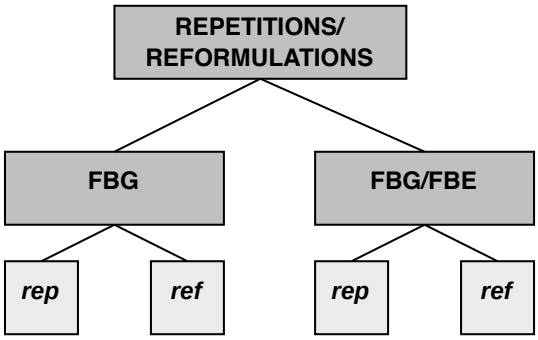

Figure 6: Analysis of repetitions and reformulations

I will focus on the functions of repetitions/reformulations in medical consultations and the structure and place of these items in sequences. The differences and similarities in the use of repetitions/reformulations between the non-Swedish and Swedish physicians and between the patients of both groups are investigated. The physicians from different cultural groups were also compared. Gender and the use of repetitions/reformulations for feedback purposes was analyzed. Quantitative differences were checked for statistical significance using $\chi 2$ tests.

The coding was again done by using the transcriptions of the recordings of medical consultations and listening to and watching the recorded consultations. The ambiguous cases were discussed and resolved with an independent analyst.

5.3.3 Qualitative analysis of repetitions and reformulations in medical consultations

5.3.3.1 Repetitions and reformulations for feedback giving (FBG)

Physicians and patients in both corpora use repetitions and reformulations to give feedback (FBG). To start with the physicians, they tend to repeat (part of) their patients' answers to their questions. This is one of ways in which physicians show their active involvement in the interaction: that they are paying attention and listening to what their patients say. In addition, this is often a strategy used to "record" new information provided by patient (e.g., a new symptom that might be worth paying attention to). Svennevig (2004) comments that such repeats often occur after statements presenting new (and often specific) information, and can therefore be called "information receipts" (p. 490). Declarative intonation is used in these cases, not interrogative. Consider the example below:

Example 57. "Heartburn" (HuD2)

Talking about stomach problems

Speaker	Transcription	Translation into English
$D:	m // men e hade du magblödning eller magsår eller [1 nej inget sånt]1	*m // but er did you have a gastric hemorrhage or a gastric ulcer [1 no nothing like that]1*
$P:	[1 nä nä nä]1 de har ja nog inte haft men ja har haft problem <1 me magen va // [2 att]2 ja har fått ja kan ju inte äta va som helst >1 [3 för då]3 / får ja **halsbränna** å [4 å andra]4 <2 å rapar >2 väldit mycke rapningar	*[1 no no no]1 I don't think I've had that but I've had problems <1 with my stomach // [2 see]2 I've got I can't eat just anything >1 [3 because then]3 / I get **heartburn** and [4 and other]4 <2 and burp >2 a lot of belching*
@ <1 hand gesture: left hand on stomach >1 @ <2 hand gesture: left hand moving up towards the throat >2		
$D:	[2 m]2	*[2 m]2*
$D:	[3 < jaha >]3	*[3 < I see >]3*
@ < head movement: nod >		
$D:	[4 < **halsbränna** >]4	*[4 < **heartburn** >]4*
@ < head movement: nod >		
$D:	jaha // ja // och e är du allergisk mot någonting	*I see // well // and er are you allergic to anything*

First, the physician gives feedback using simple feedback items, such as *m* and *jaha* together with a head nod. However, she also repeats the word *halsbränna* ('heartburn'), which constitutes more exhaustive feedback than using a simple feedback unit (e.g., *mm*, *yeah*). It is also a way of "recording" a new symptom and marking a concept important for giving a diagnosis. It can also be observed that the patient's answer is followed by the physician's confirmation of understanding, expressed by the simple feedback items *jaha // ja* ('I see // well'), before she continues with the next question concerning allergies. In similar examples from the corpora, simple feedback items such as *jaha, ja, jaså, okej, mm,* etc., are often combined with non-verbal behavior (e.g., nod, smile, long pause). In addition, the question that follows the patient's answer might concern an issue unrelated to the one being discussed – the physician raises a new topic in the interaction (see the example above, where the physician abandons the topic of stomach problems and turns to allergies) or an issue related to the one being discussed. Consider the excerpt from the interaction between an

Iranian physician and a Swedish patient below:

Example 58. "Urine" (IraD6)

The physician is asking the patient how often he uses a catheter

Speaker	Transcription	Translation into English
$D:	hur många gånger hur ofta	*how many times how often*
$P:	de beror sej på va ja dricker lite / men minst **fem** gånger [e:] om dygnet då	*it depends somewhat on what I drink / but at least **five** times [er] per day that is*
$D:	**[< fem >]**	***[< five >]***
@ < quiet >		
$D:	å läcker också	*and leaking as well*

In this example, the physician repeats the word *fem* ('five') to monitor information and provide feedback to her patient. The question *å läcker också* ('and leaking as well') is used to obtain additional information from the patient about the same issue – his use of the catheter.

Physicians also tend to paraphrase their patients' utterances for the same purpose – to give feedback, show that they are listening and retain information delivered by the patients. Reformulations represented in the data are primarily the result of grammatical and lexical changes applied to the original utterances. For example, when a physician asks which side the patient is feeling pain in, the patient answers *i höger* ('in the right'), which is followed by the physician's feedback, *i höger sida // okej* ('in the right side // okay'). Here, the physician reformulates the patient's utterance, adding the word *sida* ('side'), to provide feedback. Another example is a Hungarian physician paraphrasing the patient's answer to his question about whether she ate breakfast before the surgery. When asked if she has eaten anything, the patient replies *ja har inte ätit* ('I have not eaten'). The physician provides feedback in the form of a reformulation (lexical change of the original utterance): *fast+ fastat / okej* ('fast+ fasted / okay'). It can also be observed that the physician has problems retrieving the right word, judging from the self-interruption.

A common reformulation type in medical consultation results from a deictic shift of person, which can be explained by the influence of the activity structure: two main participants, physician and patient, are involved in the interaction. Consider the example below:

Example 59. "You know" (HuD4)

The physician is talking to the patient about the upcoming surgery

Speaker	Transcription	Translation into English
$D:	du ska opereras idag	*you will have surgery today*
$P:	m **vet** [**ja**]	*m **[I] know***
$D:	[**vet du**] m // har du nån e problem som du vill // prata om	*[**you know**] m // do you have any er problem that you want to // talk about*

Here, the physician reformulates the patient's answer by changing *jag* ('I') into *du* ('you').

The use of repetitions and reformulations by physicians is also a useful strategy to encourage patients to talk more. Consider the example below:

Example 60. "It's my back" (GerD12)

The physician is asking the patient about current problems

Speaker	Transcription	Translation into English
$D:	<1 // okej vad har du för problem >1 besvär <2 nu >2 // nu ska du <3 berätta mycke >3 <4 // >4	*<1 // okay what problem do you have trouble >1 <2 now >2 // now you must <3 tell me a lot >3 <4 // >4*
@ <1 gaze: looking down in the papers >1 @ <2 head movement: nod >2 @ <3 hand gesture: both hands in the air >3 @ <4 laughter >4		
$P:	ja de e **ryggen**	*well it's the **back***
$D:	**<1 ryggen >1 <2 ja >2**	***<1 the back >1 <2 yeah >2***
@ <1 head movement: nod >1 @ <2 head movement: to the side >2		
$D:	och så < bena >	*and then my legs*

Apart from the feedback-giving function, the physician's repetition of *ryggen* ('the back'), together with a nod, is an encouragement for the patient to continue with his story.

Like the physicians, the patients use repetitions and reformulations for the same purpose: to show they are listening to and understanding what their physicians say. The patients in both corpora choose to repeat or reformulate (part of) their physicians' questions, answers to their own questions, etc., in order to provide feedback. Consider the example below:

Example 61. "Surgery in Lundby" (SweD5)

The patient is inquiring about where the surgery will take place

Speaker	Transcription	Translation into English
$D:	nu (...) de e svårt att säja om de görs HÄR eller på **lundby** [1 eller]1 eller va de kan bli	*now (...) it's hard to say if it will be done HERE or at **lundby** [1 or]1 or whatever it may be*
$P:	[1 **lundby**]1	*[1 **lundby**]1*
$N:	de blir väl här eller [2 ja tror]2 inte dom har så lång väntetid nu å så där så att antagligen så blir de här	*it will be here [2 I don't]2 think that they have such a long wait time now but most likely it will be here*
$D:	[2 de blir här ja]2	*[2 it will be here yes]2*

Here, the physician is talking about a possible place for the surgery, and the patient repeats the name of the hospital probably in order to remember it.

Feedback is used to show contact, perception and understanding, as well as the speaker's attitude. The example below shows a patient who uses repetition to give feedback and show his agreement with the physician:

Example 62. "Heavy job" (GerD12)

Talking about the patient's job. The patient has problems with his spine. The physician states that the patient's job as a window assembler is heavy and not good for him

Speaker	Transcription	Translation into English
$D:	**// de är tungt arbete**	***// it is a heavy job***
$P:	**de e tungt arbete**	***it is a heavy job***

$D:	< du måste hämta dom och fylla i > och	*< you must fetch them and fill in > and*
@ < hand gesture: illustrating with right hand in the air >		
$D:	bäras upp å	*take up and*
$D:	< ja >	*< yes >*
@ < head movement: nod >		

By repeating the physician's utterance, the patient expresses both understanding and agreement with the evaluation of his job as being heavy. This example also illustrates how the patient helps the physician with language.

The example below illustrates the use of reformulation by a physician for the same purpose as in the example above – to show agreement:

Example 63. "You see bad" (SweD2)

Talking about the patient's eyesight

Speaker	Transcription	Translation into English
$D:	ha du haft ont i ögat nån gång	*have you ever felt any pain in your eye*
$P:	aldri de bara att / **ja ser dåligt**	*never it's just that /* ***I have poor eyesight***
$D:	**du ser dåligt me de ögat ja** // å så helt plötslit	***you have poor eyesight in that eye*** *I see // and then all of a sudden*

In addition to giving feedback by reformulating the patient's utterance *jag ser dåligt* ('I have poor eyesight'), the physician shows his agreement and confirms that he is already aware of the patient's problem.

Only one example from the data illustrates the use of reformulation to show disagreement. In the example below, the patient expresses his disagreement with the physician concerning his joking suggestion that he should put more clothes on, after the patient has complained a number of times during the consultation about constantly feeling cold:

Example 64. "I can't put on more" (SweD4P49)

Talking about the patient feeling cold

Speaker	Transcription	Translation into English
$D:	**du får ta på dej lite mer**	***you should put on a little more***
@ < chuckle >		
$P:	**nä jag kan inte ta på mej** < mer // då går det inte å > bära upp	***no I can't put on < more //*** *then it's not possible to > carry off*
@ < chuckle: D >		

By reformulating the physician's utterance *du får ta på dej lite mer* ('you should put on a little more'), the patient expresses his disagreement with what is suggested.

Repetitions and reformulations are also used to express emotions such as surprise. Consider the example below:

Example 65. "Twenty-five kilos" (SweD5)

Talking about the patient's weight loss

Speaker	Transcription	Translation into English
$D:	hur har du [mått]	*how have you [been]*

$P:	[ja] allså nu kan ja ju tala om att ja har gått ner ungefär **tjufem kilo** i vikt / från å me förra året //	*[well] now I can tell you that I've lost about **twenty five kilos** in weight / since last year*
$D:	**tjufem kilo** / de e mycke de	***twenty-five kilos** / that's a lot*
$P:	a:	*yeah*

The physician expresses his surprise about the patient's weight loss by repeating part of her utterance.

The excerpt from the interaction between a Hungarian physician and his Swedish male patient below illustrates the latter using reformulation (deictic shift of person) to express surprise and bewilderment:

Example 66. "Do I smoke?!" (HuD3P7)

The physician is questioning his elderly patient, who is very conscious of health issues (he is a teetotaler and tries to keep fit), and is surprised to be asked about smoking

Speaker	Transcription	Translation into English
$D:	**röker du**	***do you smoke***
$P:	**RÖKER JA < // >**	***DO I SMOKE** < // >*
@ < chuckle: C (the patient's daughter) and P >		
$D:	< äh ja > skoja ja vet	*< oh I > am joking I know*
@ < chuckle >		
$P:	ja sa ju de förut	*I told you that before*

The patient expresses his surprise and bewilderment by reformulating the physician's question *röker du* ('do you smoke?') as *RÖKER JA* ('DO I SMOKE?'). The patient is surprised that the physician is even asking this question as he has already mentioned earlier in the interaction that he does not smoke.

To summarize, in this section I have illustrated how non-Swedish and Swedish physicians use repetitions and reformulations of their patients' utterances (often answers to the physicians' questions) for feedback purposes (i.e., to show attention and understanding, to express emotions, agreement, disagreement, etc.). Repetitions and reformulations are also a tool used to "record" the information provided by the patients and to elicit confirmation from them. The patients are observed to use the same strategy in communicating with their physicians.

5.3.3.2 Repetitions and reformulations for feedback giving and feedback elicitation (FBG/FBE)

In addition to using repetitions and reformulations just to give feedback, the participants use them to simultaneously give and elicit feedback (FBG/FBE). Consider the example below from an interaction between an Iranian male physician and his Swedish patient:

Example 67. "Left eye" (IraD9)

History taking. The physician inquires about treatment

Speaker	Transcription	Translation into English
$D:	i vilket öga tar du droppar	*in which eye do you take drops*
$P:	**< vänster >**	*< **left** >*
@ < hand gesture: left hand pointing at left eye >		

$D:	**vänster**	***left***
$P:	**ja**	*yeah*
$D:	< > e höger har du inga [droppar]	*< > er right you don't use [drops]*
@ < gaze start: looking at the computer >		
$P:	[nej] nej // ja tar en på / moron å två på kvällen	*[no] no // I take one in / the morning and two in the evening*

The patient answers the physician's question, and the physician repeats that answer (*vänster* ['left']). The patient's next utterance is a simple feedback item *ja* ('yes'), confirming the information he has already provided, which the physician was attempting to check by using repetition. As we can see, the repetition here serves not only to show that the physician is listening and remaining involved, but also to check that the information has been understood correctly.

The repetition in the example above does not have interrogative intonation, whereas other cases presented in the data do. As I mentioned earlier, interrogative intonation encourages the interlocutor to produce a confirmation in the next utterance. Furthermore, the feedback provided may be limited to a simple feedback unit (as above), but it can also be combined with more detailed information. Consider the example below:

Example 68. "Both" (IraD8)

History taking. The patient expresses dissatisfaction with his health condition, both physical and psychological

Speaker	Transcription	Translation into English
$D:	< okej > [va e de för fel]	*< okay > [what's the problem]*
@ < head movement: nods >		
$P:	[både fysist] och psykist	*[both physically] and psychologically*
$D:	< mestadelen > alltså	*< mostly > that is*
@ < head movement: nods >		
$P:	**både och**	***both***
$D:	**< både och >**	***< both >***
@ < head movement: nods >		
$P:	**ja e: < > fysist e att ja ö e ja tror ju personlien ja har inte ja har inte sett röntgenbilderna**	***well er < > physically it's that I er er why personally I think I haven't seen the X-ray pictures***
@ < hand gesture start: left hand on right shoulder >		

The patient states that he feels bad both physically and psychologically (*både och* ('both')). This is repeated by the physician and is followed by the patient's detailed explanation of why he feels bad (both non-verbally by putting his hand on the shoulder where the pain is localized and by expressing his anxiety about not having seen the X-ray pictures).

Reformulations are also used to both give and elicit feedback. This is exemplified by the excerpt from an interaction between a Russian female physician and her male patient:

Example 69. "Run to the bus" (RusD18)

Talking during the physical examination. The physician compliments the patient on running to the bus. The patient is surprised and says that he doesn't run to the bus

Speaker	Transcription	Translation into English
$D:	då får vi se / ja ska ta / blodtrycket för att lyssna på hjärtat // men du e duktig / du RÖR på dej / du springer till < buss+ > bussen	*let's see then / I will measure / your blood pressure to listen to your heart // but you are doing well / you EXERCISE / you run to the < bus+ > bus*
@ < cutoff: bussen/the bus >		
$P:	nä: nu // **ja gå till bussen**	***why now // I walk to the bus***
$D:	**du går till bussen**	***you walk to the bus***
$P:	**ja springer gör jag inte**	***yeah I don't run***
$D:	för vadå	*why*
$P:	va	*what*
$D:	varför då varför inte	*why why not*
$P:	**nä: ja orkar inte**	***no I don't have the strength***
$D:	**de du orkar inte**	***you don't have the strength***
$P:	**nä det e va vet du / det får så ont i fötterna**	***no it's you know / my feet hurt so much so then***

As we can see, a misunderstanding that has occurred earlier in the conversation – the physician assumes that the patient runs to the bus whereas actually he walks – results in the physician complimenting her patient: *du e duktig / du RÖR på dej / du springer till < buss+ > bussen* ('you are doing well / you EXERCISE / you run to the < the bus+>'). When the patient denies this, saying *jag går till bussen* ('I walk to the bus'), the physician uses reformulation (deictic shift of person) with an interrogative intonation, *du går till bussen* ('you walk to the bus?'), to make sure she understands the patient correctly. The patient confirms it (*ja springer gör jag inte* ['yeah, I don't run']) and expresses his reason for not doing so (*nä jag orkar inte* ['no, I don't have the strength]) in response to the physician's question (*varför då varför inte* ['why, why not?']). Here, by repeating her patient's utterance, the physician is again checking to make sure she understands him correctly.

Like the physicians, the patients use repetitions/reformulations to give and elicit feedback. This strategy is used when the patients want to check if they have understood the physicians correctly. In the example below, the patient is discussing a possible time for surgery with the physician:

Example 70. "April" (IraD9)

Planning eye surgery

Speaker	Transcription	Translation into English
$D:	m / de blir nån gång i **april** månad ungefär	*m / it will be some time in the month of **april** approximately*
$P:	**april**	***april***
$D:	**ja**	***yeah***

As we can see, the patient, by repeating *april* ('April'), both signals understanding of what

the physician has said and checks whether the information is correct.

To sum up, both physicians and patients use repetitions and reformulations to give feedback and make sure they have understood information correctly, eliciting confirmation from the interlocutor.

5.3.4 Quantitative analysis of repetitions and reformulations in medical consultations

In this subsection, the quantitative results of the distribution of repetitions and reformulations used for feedback purposes by the non-Swedish and Swedish physicians and their respective patients are presented. In addition, the data will also be presented for the physicians in each cultural group – Hungarian, Iranian, and Mixed – as well as their respective patients. The data on gender will be presented as well.

General overview

The occasions when the physicians and patients use repetitions and reformulations for FBG and FBG/FBE were counted. The numbers are again expressed in PPM. To verify the significance of differences, $\chi 2$ tests were used.

Table 60: Repetitions and reformulations used by physicians and patients in PPM[30]

	Non-Swedish physicians and Swedish patients								Swedish physicians and Swedish patients							
Participant category/ type	Physician				Patient				Physician				Patient			
	FBG		FBG/FBE		FBG		FBG/FBE		FBG		FBG/FBE		FBG		FBG/FBE	
Type rep/ref	rep	ref	rep	ref	rep	ref	rep	ref	rep	ref	rep	ref	rep	ref	rep	ref
Total per category	4830	1640	1579	1382	371	148	296	38	1184	627	174	313	588	317	0	90
Total rep+ref:	6470		2961		519		334		1811		487		905		90	

Comparing **physicians**, the non-Swedish physicians produce more repetitions and reformulations than the Swedish physicians for both FBG (total rep+ref FBG: 6,470 vs. 1,811, $\chi 2 = 51.92$ [df = 1], $p < .001$) and FBG/FBE (total rep+ref FBG/FBE: 2,961 vs. 487, $\chi 2 = 37.88$ [df = 1], $p < .001$).

As I have mentioned, the fact that the non-Swedish physicians use more repetitions and reformulations for feedback purposes than the Swedish physicians might be related to their greater need to show their understanding and check the information provided by their patients, as a strategy to prevent lack of understanding/misunderstanding in communication. It might also be a result of the language acquisition process, confirming what Allwood (1993a) mentions concerning the use of repetitions and reformulations by language learners to give and elicit feedback.

An interesting observation can be made concerning the **patients**. Though no statistically significant difference can be observed in the number of FBG and FBG/FBE between the patients of the non-Swedish and Swedish physicians, the patients of the non-Swedish

30. PPM is determined as follows: number of occurrences of repetitions/reformulations ÷ number of tokens for the participant category (non-Swedish physicians = 31,037, patients of non-Swedish physicians = 26,958; Swedish physicians = 28,727, patients of Swedish physicians = 22,120) x 1,000,000.

physicians produce more repetitions and reformulations than the patients of the Swedish physicians. This might indicate that the patients in intercultural medical consultations feel a need to make sure they have correctly heard/understood what their non-native physicians are saying more than in monocultural medical consultations. In addition, this finding supports the findings of earlier research (Long's study), namely that native speakers produce more repetitions/reformulations when communicating with non-native than with native speakers.

As Table 60 shows, physicians and patients in both corpora tend to use repetitions more than reformulations for FBG. For FBG/FBE, in the ICCMedConsult corpus, both physicians and patients use repetitions more than reformulations, while the opposite is true of the Swedish physicians and patients in the SweMedConsult corpus. One might presume that it is more complicated to paraphrase than to simply repeat, and that the language competence factor might be reflected in the native speakers' tendency to paraphrase more than the non-native speakers. However, there are not enough data to draw any definite conclusions.

Gender

Concerning **gender**, in Table 61 I present the total number of repetitions and reformulations produced by the non-Swedish and Swedish physicians in each gender combination. As the number of repetitions and reformulations used by the patients in general and per gender combination in particular is too low, I cannot form any conclusions concerning patient's gender and the use of repetitions and reformulations.

Table 61: Total number of repetitions and reformulations per gender combination for non-Swedish and Swedish physicians in PPM[31]

Gender combination	Total number of repetitions and reformulations for physicians per gender combination	
	non-Swedish physicians	Swedish physicians
M phs–M pat	7661	2715
M phs–Fpat	9746	2157
F phs–F pat	10838	5433
F phs–M pat	10812	991

No clear tendency can be observed in the production of repetitions and reformulations as a function of the physician's gender. Though it is complicated to draw any conclusions concerning gender, there is a weak tendency for female physicians talking to female patients to use more repetitions and reformulations for feedback than the other gender combinations. This might reflect the female communicative style. To the best of my knowledge, no previous linguistic study has examined the differences in using repetitions and reformulations for feedback purposes as a function of gender.

31. PPM is determined as follows: number of occurrences of repetitions/reformulations ÷ number of tokens for physicians in each gender combination (non-Swedish physicians: M phs–M pat = 10,439, M phs–F pat = 9,746, F phs–F pat = 6,272, F phs–M pat = 4,580; Swedish physicians: M phs–M pat = 7,369, M phs–F pat = 9,277, F phs–F pat = 9,051, F phs–M pat = 3,030) x 1,000,000.

Cultural groups

Looking at the data for the different cultural groups, the following picture can be observed:

Table 62: Cultural groups: repetitions and reformulations in PPM[32]

	Hungarian group: physicians and patients								Iranian group: physicians and patients							
	Physician				Patient				Physician				Patient			
Participant category/ type	FBG		FBG/ FBE		FBG		FBG/ FBE		FBG		FBG/ FBE		FBG		FBG/FBE	
Type rep/ref	rep	ref	rep	ref	rep	ref	rep	ref	rep	ref	rep	ref	rep	ref	rep	ref
Total per category/ type	9078	3631	2136	2350	710	118	118	118	2310	577	1237	1237	0	0	281	0
Total rep+ref	12709		4486		828		236		2887		2474		0		281	

	Mixed group: physicians and patients							
Participant category/ type	Physician				Patient			
	FBG		FBG/ FBE		FBG		FBG/FBE	
Type rep/ref	rep	ref	rep	ref	rep	ref	rep	ref
Total per category/ type	3861	1044	1461	626	512	383	512	0
Total rep+ref	4905		2087		895		512	

Repetitions and reformulations are used most in the interactions between the Hungarian physicians and their patients, followed by the Mixed group physicians and patients and then the Iranian physicians and their patients. The physicians account for the majority of the repetitions and reformulations in all groups. As the Hungarian physicians and some of the physicians in the Mixed group had spent the least time in Sweden, this may be a factor that explains their intensive use of repetitions and reformulations compared to the Iranian physicians; that is, language learners use repetitions intensively for feedback at the early stages of the acquisition process (Allwood, 1993a). In addition, how often repetitions/ reformulations are used in the non-Swedish physicians' native languages may influence how they use them in Swedish. Unfortunately, I have not found any linguistic studies on this issue for Hungarian, Farsi, Russian, or Bosnian, so I cannot speculate further on this issue. Concerning German and Spanish, it is worth mentioning that some data on the use of feedback (primarily concerning the use of simple FB words) in these languages (as well as Swedish, Dutch, English, French, Arabic, Finnish, Italian, Punjabi and Turkish) have been presented by Allwood (1993a). As mentioned above, Allwood points out that language learners use repetitions/reformulations for feedback, especially in the initial stages of language acquisition, with a gradual decrease for the majority of learners (but not all) as language acquisition proceeds. It is interesting that speakers who are observed not to decrease

32. PPM is determined as follows: number of occurrences of repetitions/reformulations ÷ number of tokens for the participant category (Hungarian physicians = 9,352; Iranian physicians = 12,112, Mixed group physicians = 9,573) x 1,000,000.

their use of repetition for feedback include Finnish and Spanish learners of Swedish, which might indicate the influence of their native languages. (At the same time, though, it may be a "learner-specific strategy," i.e., typical for these particular learners of Swedish.)

5.3.5 Results, discussion and conclusions on feedback giving and eliciting

To summarize all the factors discussed above, the non-Swedish physicians use more repetitions and reformulations to give and elicit feedback than the Swedish physicians, which may be due to the language factor, more uncertainty concerning understanding and the consequent increased need to check the information provided by the interlocutor compared to native speakers, as well as a need to "record" information presented by the patients. The fact that the Hungarian physicians and the physicians from the Mixed group, who have spent the least time in Sweden, produce more repetitions and reformulations may confirm the influence of language acquisition on the use of repetitions and reformulations. Concerning gender, female physicians talking to female patients use somewhat more repetitions and reformulations than physicians in other gender combinations, which could reflect a more egalitarian female communicative style. The patients of the non-Swedish physicians are observed using more repetitions and reformulations than the patients of the Swedish physicians, which might be due to their greater uncertainty concerning understanding in intercultural medical consultations. In addition, as I have mentioned, the non-Swedish physicians' native languages might also have an impact.

Another point worth mentioning here is that the analysis of the non-native speakers' use of repetitions and reformulations was done in a context in which they are in a superior position to native speakers, which is an uncommon perspective in research. The analysis shows that non-native speakers in a superior position talking to native speakers in a subordinate position use repetitions and reformulations more than native speakers interacting with subordinates of the same linguistic (and cultural) background. I have mentioned a number of factors that might contribute to the non-Swedish physicians using more repetitions/reformulations for feedback than the Swedish physicians. It is important to add that the fact that the non-native speakers are responsible for the interaction might lead to their using repetitions and reformulations as a more comprehensive type of feedback.

Is there anything in the data that might signal cultural differences? As has already been mentioned, the power distance in Sweden is shorter than in the countries the non-Swedish physicians come from; thus, one can assume that a more paternalistic type of relationship between physician and patient, in which the physician has control over the interaction and core responsibility for the choice of treatment, predominates in those countries. On the contrary, the mutuality type of relationship (more common in Sweden than in the non-Swedish physicians' home countries) presupposes informality and shared responsibility for the interaction; the physician acts as a counselor or advisor (see Example 2, "It is you who decides" [SweD7]). This difference in the view of the physician's role might result in the non-Swedish physicians' using repetitions and reformulations a good deal in order to show their patients that they have the ability to bear responsibility for the interaction in spite of speaking a foreign language and (possibly) experiencing cultural differences. Repetitions and reformulations represent a way to provide more *exhaustive* feedback than other kinds of feedback. Returning to the positive aspects mentioned by the Swedish patients concerning their communication with non-Swedish physicians (section 4.6), the non-Swedish physicians'

reported meticulousness might be traced back to their use of repetitions and reformulations among other things. Repeating/reformulating (part of) what the interlocutor says is a clear and powerful way to show that one is listening to and participating in the interaction. This is essential for medical interactions in general, and intercultural medical encounters in particular.

5.4 Summary of Chapter 5

This chapter has presented a comparative analysis of some aspects of information eliciting, information giving, and acknowledgment and checking in intercultural and monocultural medical encounters. The main findings are summarized below.

Comparing the communication of Swedish and non-Swedish physicians, a number of similarities can be observed, which are primarily due to the influence of the activity. Both Swedish and non-Swedish physicians ask more questions than their patients, as a result of their right/obligation to get information from the patient in order to solve the patient's problems. Furthermore, yes/no questions are the most common question type for the physicians in both groups, which confirms the earlier research findings.

The non-Swedish physicians' use of Swedish as a foreign language also influences the interaction. The non-Swedish physicians, apparently in an attempt not to limit their patients' in answers so that they will not miss any information, use wh-questions more than the Swedish physicians. They also use phrases as questions more than the Swedish physicians, probably due to their reliance on the patient's file and because it is an easy way to ask questions. In addition, the presence of more MUQT of the particularizing type and paraphrases in the non-Swedish physicians' speech might be a sign of their need to make themselves clear. The language acquisition factor may also explain why the Swedish physicians use questions with *då* ('then') more often than the non-Swedish ones. The Hungarian physicians use more MUQT than physicians in the Iranian and Mixed groups; this might indicate that physicians who have spent less time in Sweden use MUQT to be clearer, since they are probably less confident in their language competence. Furthermore, Hungarian physicians use also more repetitions and reformulations than the physicians in the other groups, which confirms that repetitions/reformulations are used at the early stages of acquisition. At the same time, the Iranian physicians use *man* more than other non-Swedish physicians, which may reflect their better language competence due to the longer time they have spent in Sweden. However, one should bear in mind that the use of *man* and of repetitions/reformulations for feedback might also be influenced by their occurrence in the non-Swedish physicians' native languages. The fact that the Swedish patients of non-Swedish physicians use more FBG/FBE than the patients of Swedish physicians is also motivated by their increased need to check information.

Cultural impact can be seen in the use of *man*, which reflects the more indirect Swedish way of talking. One possible reason for using repetitions and reformulations as a more exhaustive type of feedback is a more paternalistic relationship style, which means that the physician takes core responsibility for the interaction.

Concerning gender, the male-male consultations include more yes/no questions than the interactions between two females and questions with *eller* ('or') are used more by female non-Swedish physicians; these findings might indicate that male physicians are more inclined

to place restrictions on their patients' answers (and possibly to ask more specific questions), while female physicians adopt a more general communicative style.

Chapter 6: Overall comparative analysis of the ICCMedConsult and SweMedConsult corpora

In this chapter, a general analysis and comparison of the "intercultural" and "Swedish" medical consultations is presented. The aim is to tackle the overall differences and similarities in communication in intercultural medical consultations (i.e., consultations between non-Swedish physicians and Swedish patients) and monocultural ones (i.e., consultations between Swedish physicians and their Swedish patients). The basis of my analysis is primarily statistical data obtained for each category of participants, using the computer programs for processing transcriptions – *Göralt* ('do-all') and *Tal-till-tal* ('speech to numbers') – and *Lgconc*, a concordance program (see Chapter 3). The statistics cover word length and utterance length, pauses, vocabulary richness (Vocab), parts-of-speech distribution and the most common words for each part of speech. For a general description of the corpora and the participant groups, see Table 19, in Chapter 3.

Below, a brief overview of the contents of Chapter 6 is provided.

Table 63: Layout of Chapter 6

Section #	Title	Empirical data used
6.1	Word length and vocabulary richness (Vocab)	recordings of medical consultations
6.2	Mean length of utterance (MLU)	
6.3	Pauses	
6.4	Parts-of-speech distribution	
6.5	Most common words in each part of speech	
6.6	Summary of Chapter 6	

The quantitative data have been combined with the qualitative analysis of interactions (i.e., examples from the transcriptions are presented when applicable). The non-Swedish physicians have been compared with Swedish physicians and the patients of non-Swedish physicians with the patients of Swedish physicians.

T-tests and $\chi 2$ tests were used to check the significance of differences, where applicable. The differences are statistically significant at the 99% level or better (in the absence of any mention to the contrary). Due to space limitations, I will not include the t-test and $\chi 2$ values in the tables in the following sections. Instead, I will underline the numbers for which there are significant differences in the data concerning word length, Vocab, mean length of utterance (MLU), pauses and parts-of-speech distribution. In presenting the numerical results concerning the most common words in each part of speech (i.e., most common adjectives, verbs, etc.) for each participant group (the non-Swedish and Swedish physicians and the patients of both groups), I will first present words for which no significant differences in frequency are observed, followed by those that are more common for the non-Swedish physicians and their patients and then those that are more common for the Swedish physicians and their patients.

6.1 Word length and vocabulary richness (Vocab)

In this section, the data on word length and vocabulary richness are presented. Table 64 contains information about **mean word length**, measured in letters. The t-test was used to test the differences for statistical significance.

Table 64: Mean word length

Categories	Mean word length
Non-Swedish physicians	4.14
Swedish physicians	4.00
Patients of non-Swedish physicians	3.78
Patients of Swedish physicians	3.94

The table shows that the mean word length in both corpora is between 3 and 5 letters. Comparing **physicians**, the non-Swedish physicians use longer words than the Swedish physicians. As for the **patients**, the patients of Swedish physicians use longer words than the patients of non-Swedish physicians. A tentative explanation of the greater mean word length for the non-Swedish physicians than the Swedish physicians is the wider variety of consultation types included in the ICCMedConsult corpus compared to SweMedConsult (see Methodology, Table 19, for a description of the corpora). More varied consultation types result in more varied vocabulary, which might be reflected in higher word length values.

Is the vocabulary in the ICCMedConsult corpus more varied than in the SweMedConsult corpus? The data on **theoretical vocabulary** (Vocab 10000) are presented below. Vocab is a vocabulary richness measure originally referred to as theoretical vocabulary; it shows how lexically varied the vocabulary is. It can be defined quite simply as the expected number of word types when a certain number of word tokens (words) are selected randomly. Theoretical vocabulary is a property of a whole corpus, not of individual activities and utterances, which makes statistical significance difficult to calculate (for detailed information see Gunnarsson, 2006). The values are presented in Table 65.

Table 65: Theoretical vocabulary (Vocab 10000)[33]

Categories	Vocab 10000
Non-Swedish physicians	1661
Swedish physicians	1627
Patients of non-Swedish physicians	1588
Patients of Swedish physicians	1503

The table shows that the vocabulary used by the non-Swedish physicians and their patients is more varied than the vocabulary of the Swedish physicians and their patients.

As I have already mentioned, a reasonable explanation of the higher values for word length and vocabulary richness in the ICCMedConsult corpus than the SweMedConsult corpus is the greater variety of consultation types in the former.

For example, such words as *uppvakningsavdelning* (‘recovery ward’), *ingrepp* (‘operation’), *operationsbord* (‘operating table’), etc., are common in the consultations with the anesthetists

33. No test was used to check the significance of differences.

(the Hungarian physicians), who are included in the ICCMedConsult corpus but not in the SweMedConsult.

Another factor is the deviant pronunciation of the non-Swedish physicians, who are using Swedish as a foreign language. This might result in an increase in vocabulary richness values (the program counts the words with deviant pronunciation as new word types). Consider the following utterance by a Hungarian physician (HuD1):

`$D: ja läste journalen och de står här att` **`dy`** `har ont i ryggen`
$D: I read your file and it says here that ***you*** *have pain in your back*

The personal pronoun *du* ('you') is pronounced as "dy" by the physician. Other examples are *dar* (där) ('there'), *såk (sak)* ('thing'), *ättit* (ätit), ('eaten'), etc. These and similar deviant pronunciations in the non-Swedish physicians' speech may influence their vocabulary richness values.

In addition, as I discussed in Chapter 4, the non-Swedish physicians report experiencing problems finding Swedish colloquial terms instead of medical terminology (e.g., *bukspottkörtel* instead of *pancreas* ['pancreas']) when communicating with their Swedish patients; obviously, the use of medical terminology can influence Vocab. The non-Swedish physicians even use words from their native languages or other languages (e.g., English, German) and this might also be reflected in higher Vocab values.

Concerning the differences between the **patients**, I explain them primarily by the greater variety of consultation types and, consequently, of topics discussed.

To summarize, the non-Swedish physicians' speech is characterized by longer words and more varied vocabulary than the speech of the Swedish physicians. Tentative explanations are the differences in the variety of consultation types as well as factors that arise from the non-Swedish physicians' using Swedish as a foreign language, such as deviant pronunciation and use of medical terminology and words from other languages than Swedish when they experience language problems in an interaction.

6.2 Mean length of utterance (MLU)

MLU provides information about the syntactic complexity of discourse. It is defined as the average number of words in each utterance. An utterance is a vocal contribution, defined as "a sequence of words uttered by one participant bounded either by silence or by the uninterrupted speech of another participant (or by the start/end of the activity)" (Nivre et al., 2004). When two participants produce a phrase collectively, their contributions[34] are counted as two separate utterances. Pauses are allowed within the utterance, and the utterance ends only when another participant talks without overlap, or it is clear that the activity/subactivity is over. The MLU values are presented in Table 66 below.

Table 66: Mean length of utterance (MLU)

Categories	MLU
Non-Swedish physicians	8.11
Swedish physicians	9.70
Patients of non-Swedish physicians	6.63
Patients of Swedish physicians	7.4

As one can see, the average number of words in each utterance ranges between 6 and 10. Concerning the **physicians**, the t-test shows a significant difference at the 95% level between the two groups: the non-Swedish physicians use shorter utterances than the Swedish physicians. This is not surprising as it is often problematic to construct longer utterances in a foreign language. No statistically significant difference can be observed between the **patients**. Consider the example below in which an Iranian physician is talking to her patient:

Example 71. "If you have problems" (IraD7)

Prescription. Talking about the patient's urinary infection

Speaker	Transcription	Translation into English
$D:	men e om om du har // riktig // besvär me de [<1 urinvägsinf+ >1] du kan ta / e de finns mediciner som du kan ta i sex månader <2 (...) >2	*but er if if you have have // real // trouble with [< 1 urinary inf+ >1] you can take / er there are medicines you can take for six months <2 (...) >2*
@ <1 cutoff: urinvägsinfektion/urinary infection >1 @ <2 quiet >2		
$P:	[ja]	*[yeah]*

The example illustrates the kinds of problems the physicians experienced in formulating long utterances. Pauses, self-interruptions, and hesitation sounds can be observed.

To sum up, the non-Swedish physicians produce shorter utterances than the Swedish physicians, which might reflect their problems formulating messages in Swedish.

34. In the transcription produced according to the GTS standard, the basic unit is the contribution (i.e., "a continuous stretch of communicative activity from one participant, bounded either by inactivity or by communicative activity from another participant"), which can be expressed vocally, through bodily gestures, or both.

In addition to being reflected in MLU values, problems with sentence construction also result in a slower tempo of interaction, reflected in the number of pauses in the ICCMedConsult and SweMedConsult corpora, discussed in the following section.

6.3 Pauses

In this section, the data on pauses are presented. PauPTok stands for the percentage of pauses in relation to the total number of words (word tokens), that is, the average number of pauses per word token (word), multiplied by 100: (Pauses × 100) / (Pauses + Tokens). In the transcriptions, pauses are indicated with one (/), two (//) or three slashes (///), depending upon their length. How long a pause is is up to the transcriber to decide, but in general, a long pause lasts for many seconds and a short one about as long as it takes to pronounce a word at the current speed of talking. If the length of a pause is somewhere between these two extremes, it is marked with two slashes and considered to be an intermediate pause. As pause length is a subjective estimation, I obtained statistics for the number of pauses only, ignoring their length. A t-test was used to test the significance of differences.

Table 67: Pauses

Categories	PauPTok
Non-Swedish physicians	10.38[35]
Swedish physicians	5.90
Patients of non-Swedish physicians	7.30
Patients of Swedish physicians	5.26

As Table 67 shows, more pauses are observed in the speech of the non-Swedish than the Swedish **physicians**. This may be due to language problems; the non-native speakers need more time to formulate a message (see Example 71 above). Many pauses and hesitation sounds are observed in their speech. I will discuss the use of hesitation sounds in more detail in section 6.5.8.

Similarly, the **patients** of non-Swedish physicians produce more pauses than the patients of Swedish physicians. This might represent a more or less conscious strategy used by the patients in order to make it easier for the physicians to understand what they are saying. Consider the example below, which illustrates both the non-Swedish physician's language problems and his patient's use of slow speech and gestures in order to make it easier for the physician to understand:

35. In Berbyuk et al. (2006), slightly different numbers for PauPTok are presented: non-Swedish physicians 10.07, patients of non-Swedish physicians 6.92, Swedish physicians 5.52, and patients of Swedish physicians 5.51. In my final review of the data, some corrections were made to the transcriptions, slightly changing the values, but not the results and the conclusions.

Example 72. "Nothing helps" (GerD12)

The patient is complaining that nothing helps with her hands

Speaker	**Transcription**	**Translation into English**
$P:	och e // sen hade ja fått väldit ont i < ryggen då i mina bäckenleder här >	*and er // then I got much pain in < my back and in my pelvis joints here >*
@ < hand gesture: P is showing her back with both her hands >		
$D:	mhm	*mhm*
$P:	/// mhm	*/// mhm*
$P	och e // då fick ja åka på en röntgen // och e då konstatera dom att de e / förslitningsförändringar då	*and er // then I had to go for an X-ray // and er then they stated that it's / repetitive strain changes*
$D:	< m >	*< m >*
@ < head movement: D nods >		
$P:	i ryggen	*in my back*
$D:	m	*m*
$P:	och sen så e // ja så prova vi en massa olika mediciner då // har ja [1 gjort då]1 mot värk å inflammation å	*and then er // well then we tried many different medicines // so I [1 have]1 for pain and inflammation and*
$D:	[1 m]1	*[1 m]1*
$D:	< m: >	*< m: >*
@ < hand gesture: D is writing >		
$P:	< ja allt som tänkas kan då // [2 å]2 de finns ingenting som har hjälpt // de finns ingenting som tar bort värken >	*< yeah everything one can think of // [2 and]2 there is nothing that has helped // there is nothing that relieves the pain >*
@ < hand gesture: D is writing >		

The patient is speaking more slowly than usual so the physician can understand and write down what is being said.

To summarize, the non-Swedish physicians and their patients produce more pauses than the Swedish physicians and their patients. This might be a consequence of the non-Swedish physicians' experiencing problems formulating their messages in Swedish and their Swedish patients' attempting to adjust their speech tempo to ensure understanding on the physicians' side.

6.4 Parts-of-speech distribution

The parts-of-speech distribution in the two corpora is presented in this section. As Gunnarsson (2006) mentions, the tagger distinguishes nine traditional part of speech: adjective, adverb, conjunction, interjection, noun, numeral, preposition, pronoun and verb. In addition, feedback and OCM (own communication management) are included. Feedback includes words used for "the giving or eliciting information concerning contact, perception, understanding and attitude, by regularized linguistic means" (Allwood, 1993a, p. 3). OCM stands for "processes that speakers use to regulate their own contributions to communicative interaction" (Allwood, 2003, p. 8). OCM comprises hesitation sounds, lengthening of continuants, self-interruption, self-repetition, etc. The parts-of-speech tagger recognizes only hesitation sounds and interrupted words.

The error rate of the parts-of-speech tagger is 3%; a common problem is that the tagger may not recognize a word. In this case, the word is always tagged as a noun. In our study, the non-Swedish physicians, as mentioned above, may have an accent, which results in deviant pronunciation, which in turn causes the word to be tagged as a noun. I have tried to prevent this error by correcting the words with deviant pronunciation before running the program. The differences were tested for statistical significance using the $\chi 2$ test.

Table 68 presents the parts-of-speech distribution for each participant group.

Table 68: Parts-of-speech distribution

Part of Speech	**adj**[36]	**adv**	**conj**	**fb**	**interj**	**n**	**num**	**ocm**	**prep**	**pron**	**v**
Speakers/proportion	**proportion (%)**										
Non-Swedish physicians	3.92	13.57	7.66	9.18	0.57	12.63	1.19	4.44	5.44	20.67	19.41
Swedish physicians	3.42	18.16	8.80	6.50	0.16	10.52	0.60	1.10	6.22	22.66	20.77
Patients of non-Swedish physicians	3.01	16.26	7.14	12.24	0.62	10.42	1.30	2.41	5.59	21.39	18.70
Patients of Swedish physicians	2.78	17.56	7.95	11.91	0.38	8.30	0.66	1.84	5.50	22.40	19.28

T**he table shows that pronouns, verbs, adverbs, nouns and feedback are the most common parts of speech in medical consultation.** This is not surprising, as the same result is found fairly consistently for all spoken language (Allwood, 2001a); it also reflects the nature of medical consultation as a social activity. Because interaction occurs between a limited number of participants, most often two (physician and patient), and the physician must inquire about the patient's state of health while the patient provides information, the personal pronouns *du* ('you') and *jag* ('I') are used a lot. The participants' need to express, for example, a state of health (feeling well/unwell), time (taking the treatment now/ tomorrow/today), etc., accounts for the heavy use of adverbs. It is likely that the importance of showing listenership and understanding and answering questions explains the frequent use of feedback, especially by the patients, who need to answer the physicians' questions. More information is provided in section 6.5.

Lets us now turn our attention to the differences between the various participants. **The non-**

36. The abbreviations used are: adj = adjective, adv = adverb, conj = conjunction, fb = feedback word, interj = interjection, n = noun, num = numeral, ocm = own communication management, prep = preposition, pron = pronoun, v = verb.

Swedish physicians use more adjectives, feedback words, interjections, nouns, numerals and OCM than the Swedish physicians.

The language problems experienced by the non-Swedish physicians are reflected in higher proportions of OCM and feedback. As I have already mentioned, the need to take more time than native speakers is associated with the use of hesitation sounds, reformulation, etc. One consequence of this is that the non-Swedish physicians have higher OCM values than the Swedish ones. Concerning feedback, as we have seen, the non-Swedish physicians may express listenership and attention to a higher degree than the Swedish physicians in order to assure their patients that they are listening to and understanding them. They know the patients might be anxious (and as the patients' responses to the questionnaire show, they *are* anxious) about this matter due to the physicians' using Swedish as a foreign language. This also supports the analysis of repetitions and reformulations presented in the section above.

The greater variety of consultation types also explains the higher proportion of nouns in the non-Swedish physicians' speech. The same applies to the use of numerals, although a closer look at the data is needed. It is interesting that adjectives and interjections are also used more often by the non-Swedish physicians. Does the more intensive use of these words indicate the non-Swedish physicians' tendency to evaluate more and to be more emotionally expressive than Swedish physicians? I will return to these questions in the analysis of the most common words in each part of speech in section 6.5 below.

The Swedish physicians use more adverbs, conjunctions, prepositions, pronouns and verbs than the non-Swedish physicians. The greater syntactic complexity of the speech of the native speakers compared to the non-native ones may explain their more intensive use of prepositions and conjunctions. I will discuss this and the use of adverbs, pronouns and verbs in more detail in section 6.5.

More similarities can be observed in the parts-of-speech distribution in the speech of the patients of the non-Swedish and the Swedish physicians than in the physicians' speech. No significant differences can be observed in the proportions of adjectives, feedback, prepositions and verbs. However, **the patients of non-Swedish physicians use more interjections, nouns, numerals and OCM than the patients of Swedish physicians. The patients of Swedish physicians use more adverbs, conjunctions and pronouns.** This result partially reflects the differences in the physicians' speech mentioned above. It can be explained by Giles' Speech Accommodation Theory: participants accommodate their communicative behavior by attempting (consciously or not) to adjust it, and speak similarly to their interlocutors (convergence) (Giles et al., 1991).

In summary, the influence of activity, the non-Swedish physicians' use of Swedish as a foreign language and possibly cultural factors all influence the parts-of-speech distribution. The fact that pronouns, adverbs, and feedback are some of most common parts of speech in medical consultations is primarily due to the activity factor. The presence of more OCM in intercultural medical consultations is probably a result of the non-native speakers' language problems, as is the use of conjunctions and prepositions. The fact that the non-Swedish physicians use more verbal feedback than the Swedish physicians may also be a consequence of their need to assure their patients that they understand what is being said. Cultural factors might be reflected in the greater use of interjections and adjectives by the non-Swedish physicians, which might reflect more emotionality and a higher tendency to evaluate compared to the Swedish physicians,

issues that I investigate in more detail in the sections below.

In order to get a more specific picture, we shall now look more closely at the vocabulary used by the participants in medical consultations.

6.5 Most common words in each part of speech

In this section, the most common words in each part of speech for each participant category (i.e., non-Swedish physicians and Swedish physicians and their respective patients) will be presented, compared and discussed.

The data are presented as follows. I present the 10 most common words in each part of speech (ranks 1 to 10) per participant category. However, some words are among the 10 most common for one category of participants (e.g., the non-Swedish physicians), but not for the one with which they are being compared (the Swedish physicians). In this case, the frequencies of these words are presented for both categories, even though they are not ranked among the 10 most frequent words for one group. In such cases, I do not specify the rank but mention that the word ranks below 10 (<10).

It is worth mentioning here that the different grammatical forms of adjectives, nouns, pronouns, numerals and verbs are merged in the frequency counts; for example, the frequency of *bra* ('good') includes its comparative and superlative forms (*bättre, bäst* ['better, best']) as well as the plural superlative form *bästa* ('best', pl.), if they are represented in the data.

Numbers are given in parts per million (PPM), that is, the number of occurrences of each word type divided by the total number of words × 1,000,000. The numbers are rounded. To test the significance of differences, $\chi 2$ tests were used. Only differences at the 99.5% level or better are considered. Using the concordance program and the transcriptions, I analyzed the use of words in context.

As mentioned above, I will first present the words for which no significant difference in frequency is observed, followed by those which are more common for the non-Swedish physicians and their patients and then those that are more common for the Swedish physicians and their patients.

6.5.1 Adjectives

The most common adjectives used by the non-Swedish physicians, the Swedish physicians and their respective patients are presented in Table 69.

Table 69: Adjectives (in alphabetical order) in PPM

Physicians					
Word	**Translation**	**Non-Swedish physicians**		**Swedish physicians**	
		freq	**rank**	**freq**	**rank**
No significant difference in frequencies					
dålig, sämre, sämst(a), värre	*bad, worse, worst poor (er, est)*	1192	3	801	6
hel(a)	*whole*	677	10	940	5
höger	*right*	838	7	313	9
liten/t, lilla, små	*little small*	967	5	1149	3
normal(a)	*normal*	934	6	418	8
själv(a)	*itself*	1031	4	1114	4
sådan(a)/t sån(a)/t	*such like this/that*	1933	2	2750	2
trött(are)	*(more) tired*	408	<10	226	10
viktig(a)/t (are, ast)	*(more, most) important*	805	8	627	7
More common for the non-Swedish physicians					
bra, bättre, bäst(a)	*good, better, best fine*	5542	1	3481	1
färdig(a)/t	*ready, finished*	1031	4	139	<10
lång(a)/t, längre	*long(er)*	773	9	174	<10
More common for the Swedish physicians					
rädd(a)	afraid scared	0	<10	418	8
svår(are, ast)	(more, most) difficult	193	<10	801	6

Patients					
Word	**Translation**	**Patients of non-Swedish physicians**		**Patients of Swedish physicians**	
		freq	**rank**	**freq**	**rank**
No significant difference in frequencies					
bra, bättre, bäst(a)	*good, better, best fine*	3524	1	2622	2
hel(a)	*whole*	1224	4	1175	3
höger	*right*	594	9	226	7
liten/t, lilla, små	*little small*	742	6	568	5
lång(a), långt, längre	*long, longer*	556	10	181	8
senaste	*latest*	185	<10	226	7
själv(a)	*itself*	816	5	904	4
svår(are, ast)	*(more, most) difficult*	482	<10	181	8
sådan(a)/t sån(a)/t	*such like this/that*	2782	2	3074	1
trött (are)	*(more) tired*	408	<10	226	7
More common for the patients of the non-Swedish physicians					
dålig, sämre, sämst(a), värre	*bad, worse, worst, poor (er, est)*	1781	3	568	5
hög(re, st)	*high(er, est)*	631	8	90	9
viktig(a)/t (are, ast)	*(more, most) important*	668	7	45	10
More common for the patients of the Swedish physicians					
rädd(a)	*afraid, scared*	37	<10	407	6

To start with a **general overview**, adjectives that positively or negatively evaluate something are common; the adjectives *bra* ('good', 'fine') and *dålig* ('bad', 'poor') and their inflected forms are among the 10 most common adjectives for the physicians and patients in both corpora. This can be explained by the influence of activity. The participants in medical consultations need to evaluate the patient's state of health and/or changes therein, characteristics of symptoms, positive/negative examination/test results, etc. Some examples are provided below:

Example 73. Use of the adjectives bra (‘good’, ‘fine’) *and dålig* (‘bad’, ‘poor’) *and their inflected forms in medical consultations*

$D: känns **bra** också *$D: feels **good** too*	inquiry about state of health (physician)
$D: men om de kan vi göra så vi kan planera å göra en operation i höger ögat å se hur mycke synen blir **bättre** *$D: but about this we can plan to do surgery on your right eye and see how much your eyesight becomes **better***	change of state of health (physician)
$D: det beror på att du har en lite **dålig** cirkulation du har dom åderbråken *$D: it’s because you have a somewhat **bad** circulation that you have those varicose veins*	characteristics of symptoms
$D: men hb e **bra** *$D: but HB is **good***	characteristics of results (physician)
$D: annars är ju **bästa** behandling att gå så mycket som möjligt *$D: otherwise the **best** treatment is of course to walk as much as possible*	characteristics of treatment
$P: ja mår **bäst** på kvällen kan man säga *$P: I feel **best** at night one can say*	state of health (patient)
$P: du pratar ju **bra** svenska *$P: why you speak **good** Swedish*	other

In a medical consultation, the history taking, physical examination and prescription stages require the use of certain adjectives. The need to show on the body where the symptom(s) is/ are located, and to provide information about the course of treatment or the clinical picture explains why such adjectives as *hel* (‘whole’), *höger* (‘right’) and *liten* (‘little’, ‘small’) and their inflected forms are among the 10 common adjectives for physicians and patients in both corpora. In addition, the need to emphasize the importance of something (e.g., following the treatment plan) motivates the use of *viktig* (‘important’). Below, some examples of the use of these adjectives are presented:

Example 74. Use of the adjectives hel (‘whole’)*, höger* (‘right’)*, liten* (‘little’, ‘small’)*, viktig* (‘important’) *and their inflected forms in medical consultations*

hel ('whole')	$D: men man kände **hela** tiden svaghet eller *$D: but one felt weakness **all** the time or* $P: annars hade ja ont i **hela** kroppen *$P: otherwise I felt pain in my **whole** body*	totality/undividedness (e.g., talking about symptoms, time period, etc.)
höger ('right')	$D: titta åt **höger** // vänster *$D: look to the **right** // left*	direction (e.g., in eye examinations)
liten ('little')	$D: vi sätter en **liten** tub i halsen *$D: we’ll insert a **small** tube in your throat*	size
viktig ('important')	$D: aa de du framför allt har här så är det ett inflammerat **viktigt** muskelfäste i / själva axelleden *$D: well what you have here above all is an inflammation in an **important** muscular attachment in / the shoulder joint itself*	importance of something

Another adjective common for all the participants is the adjective *sådan* (‘such’, ‘like this/ that’) and its inflected forms (pronounced in Swedish as *sån*). It is often used when the speaker is unsure how to formulate the message (e.g., what word should be chosen). In the data, it is observed to be used by the patients talking, for example, about their medical history and having problems choosing a word:

$P: ja har **sån** här / värme +
*$P: I have **such** warm +*

$P: ja har vart inne på **sån** där e // undersökning
*$P: I have been at the hospital for **such** er // treatment*

Sånt is also used in constructions like *såna saker* ('such things'), *sånt här/där* ('like this/ that'), when the participants cannot specify what they want to say; in some cases, emotional stress and anxiety may be a cause. In the example below, the patient is complaining to the physician about an unpleasant examination that she experienced during a previous consultation with one of the physician's colleagues:

$P: å ja vet inte varför e de blev så // å så fick ja en väldi **sån** där e klåda över hela här nere
*$P: and I don't know why er it became like this // and then I got a terrible **such** er irritation over the whole area down here*

Another adjective that is commonly used by for all participants is *själv* ('itself'). Its use is also linked to the influence of activity. In medical consultation, *själv* is used to emphasize something in order to be more specific in, for example, delivering information:

$D: och men annars **själva** graden av gråstarr e inte jättemycket
*$D: and but otherwise the degree of cataract **itself** is not very much (a huge lot)*

The adjective *normal* ('normal') is among the 10 most common for the physicians in both corpora, but not the patients. Here, the activity factor has an impact. It is physicians rather than patients who have the competence to assess something as being "normal" in medical consultation. Analyzing the concordance lists, the adjective *normal* is used in constructions like *leverproverna ser helt normalt ut* ('the liver tests look completely normal'), *dosen är normal* ('the dosage is normal'), *känseln e normal* ('sensitivity is normal'), etc., which are produced by the physicians.

The adjective *rädd* ('afraid', 'scared') occurs more in the Swedish corpus due to the discussions of psychological issues in a few of the interactions. It is worth mentioning here that the extent to which psychological issues are discussed in consultations may be related to cultural factors, but I do not have any basis in my data for making any claims concerning this issue.

Concerning **similarities between the non-Swedish and Swedish physicians**, such adjectives as *dålig* ('bad', 'poor'), *hela* ('whole'), *höger* ('right'), *liten* ('little', 'small'), *normal* ('normal'), *själv* ('itself'), *sån* ('such', 'like this/that'), *trött* ('tired'), *viktig* ('important') and their inflected forms do not differ significantly in frequency between the two groups. As for **differences**, the adjectives *bra* ('good', 'fine'), *färdig* ('ready'), *lång* ('long') and their inflected forms are significantly more frequent for the non-Swedish than the Swedish physicians, while the opposite is true of the adjectives *rädd* ('afraid', 'scared') and *svår* ('difficult'), which are more common for the Swedish physicians.

To start with *bra*, can one presume that non-Swedish physicians tend to make positive evaluations more than the Swedish physicians? To answer this question, a detailed analysis of positive-valence adjectives was done. Consider Table 70 below:

Table 70: Adjectives which positively evaluate something: physicians (absolute numbers)

Word	Translation	Non-Swedish physicians	Swedish physicians
angenäm	*pleasurable*	1	0
duktig	*clever, good*	1	2
effektiv(t)	*effective*	1	3
fantastisk	*fantastic*	1	0
fin(a)/t,	*fine*	5	1
glad(a)	*glad, happy*	0	4
god, gott	*good*	1	5
intressant	*interesting*	5	0
jättebra	*very good, great*	15	3
klok	*wise*	1	5
perfekt	*perfect*	13	1
rolig	*funny (comic)*	0	1
skön	*lovely*	2	5
snäll	*kind*	10	2
spännande	*exciting, interesting*	2	0
trevlig	*pleasant, nice*	4	0
vacker	*beautiful*	1	0
väldig	*enormous*	0	3
Total:		**63**	**35**

As Table 70 reveals, the non-Swedish physicians use more positive-valence adjectives than the Swedish physicians. Another interesting observation arises from the analysis of word frequencies: adjectives and adverbs with the prefix *jätte-* ('giant, terrific') attached to them are used more by the non-Swedish than the Swedish physicians:

Table 71: The prefix *jätte-* used by non-Swedish and Swedish physicians

Non-Swedish physicians		Part of speech	# of occurrences	Swedish physicians		Part of speech	# of occurrences
Word	Translation			Word	Translation		
jättebra	*very good*	adj	15	jättebra	*very good*	adj	3
jättebra	*very well*	adv	14	jättebra	*very well*	adv	1
jättefort	*very fast*	adv	1	jättedåli	*very bad*	adj	1
jätteförsikti	*very careful*	adj	1	jätteklokt	*very wise*	adv	1
jättejobbi	*very tough*	adj	1	jättemycke	*very much*	adj	2
jättegärna	*very willingly, with much pleasure, would love to*	adv	1	jättemånga	*very many*	adj	2
jättekänslig	*very sensitive*	adj	1	jätteont	*much pain*	n	1
jättelite	*very little*	adj	2	jättesmal	*very thin, very skinny*	adj	1
jättelång	*very long*	adj	2	jättestor(a,-t)	*very big*	adj	3

jättemycket	*very much*	adj	1	jättesvårt	*very difficult*	adj	1
jättemycke	*very much*	adv	8	jätteviktit	*very important*	adj	1
jättemånga	*very many*	adj	1				
jättenödvändit	*very necessary*	adv	1				
jätterädd	*very scared*	adj	1				
jättesnällt	*very nice, very kind*	adj	1				
jättesvår	*very difficult*	adj	1				
jättetacksam	*very grateful*	adj	1				
jättevikti	*very important*	adj	1				
jättevälkomna	*very welcome*	adj	8				
Total			**62**				**17**

Although one can question whether there are enough data to draw a definite conclusion, it appears that the non-Swedish physicians are somewhat more likely to evaluate things positively (e.g., *en bra salva* [‘a good ointment’], *en bra anamnes* [‘a good anamnesis’]) and to use over-evaluations when talking to their patients than the Swedish physicians are. A possible explanation is that this is due to cultural differences in communicative styles: there are overstatement and understatement cultures, and the Swedish physicians are representative of the latter. These phenomena might also be ways of expressing oneself more clearly. Furthermore, it is worth mentioning that *jätte-* is a very productive prefix, which is easy for non-Swedes to notice in spoken language; this is another possible explanation of its intensive use by the non-Swedish physicians.

The adjective *färdig* (‘ready’, ‘finished’) is significantly more common in the output of the non-Swedish than the Swedish physicians. This adjective is used by physicians to terminate the examination procedure, consultation, etc. (which explains its lower use by the patients), for example:

`$D: vi e **färdiga** med e samtalet`
*$D: we are **finished** with er the conversation*

Here, the physicians’ native language plays a role. A significant proportion of occurrences of this adjective in the ICCMedConsult corpus are the result of one German physician (GerD12) using it like the German *fertig*; he accounts for 26 out of 32 occurrences.

Concerning *lång* (‘long’), the eye examinations included in the ICCMedConsult corpus necessitate the use of such constructions as *långt* + *håll/avstånd* (‘long + distance’). Consequently, this adjective is used more by the non-Swedish than the Swedish physicians.

The adjectives *rädd* (‘afraid’, ‘scared’) and *svår* (‘difficult’) and their inflected forms are more common for the Swedish than the non-Swedish physicians. I have already commented on *rädd*, and I cannot provide a good explanation for *svår*.

The differences between the **patients** of the non-Swedish and the Swedish physicians are observed in the frequencies of the adjectives *dålig* (‘bad’, ‘poor’), *hög* (‘high’), and *viktig* (‘important’), which are more commonly used by the patients of non-Swedish physicians, and *rädd* (‘afraid’, ‘scared’), which is used more by the patients of Swedish physicians. These differences can be explained by the differences in the topics of their interactions.

6.5.2 Adverbs

The most common adverbs used by the participants are presented below.

Table 72: Adverbs (in alphabetical order) in PPM

Physicians					
Word	**Translation**	**Non-Swedish physicians**		**Swedish physicians**	
		freq	**rank**	**freq**	**rank**
No significant difference in frequencies					
inte	*not*	15530	1	13541	4
lite	*a little, a bit, somewhat*	5058	7	6231	7
nu	*now*	5413	5	5326	8
när	*when*	3673	10	5187	9
More common for the non-Swedish physicians					
hur	*how*	5348	6	3481	<10
mycket	*much*	4027	9	2019	<10
också	*also, too, as well*	4704	8	2924	<10
More common for the Swedish physicians					
där	*there*	3512	<10	7136	6
då	*then*	5735	4	14655	3
här	*here*	7862	3	15038	2
ju	*of course as you know*	2900	<10	9642	5
så	*so, such*	15047	2	28510	1
ut	*out*	1450	<10	3551	10

Patients					
Word	**Translation**	**Patients of non-Swedish physicians**		**Patients of Swedish physicians**	
		freq	**rank**	**freq**	**rank**
No significant difference in frequencies					
där	*there*	6566	6	8183	5
då	*then*	13688	3	13879	3
här	*here*	8421	5	6781	6
inte	*not*	18251	2	19394	2
ju	*of course as you know*	12723	4	13834	4
lite	*a little, a bit, somewhat*	3821	9	4566	9
mycket	*much*	3376	10	2939	<10
nu	*now*	6121	7	6420	7
när	*when*	4897	8	5335	8
så	*so, such*	20884	1	26311	1
väl	*probably, well*	3301	<10	3933	10

To start with a general overview, Table 72 suggests that certain adverbs, including *då* ('then'), *här* ('here'), *inte* ('not'), *lite* ('a little', 'a bit', 'somewhat '), *nu* ('now'), *när* ('where') and *så* ('so', 'such') are among the most common adverbs for all the participants. The use of all of these adverbs except *så* can be traced back to the influence of the activity. Consider the examples below:

Example 75. Use of the adverbs *då* ('then'), *här* ('here'), *inte* ('not'), *lite* ('a little', 'a bit', 'somewhat '), *nu* ('now') *and* *när* ('where') *in medical consultations*

då ('then')
när ('when')
nu ('now')
	`$P: då va ja sexton år`
	$P: I was sixteen ***then***
	
	`$D: när när har du ramlat`
	$D: ***when*** *when did you fall*
	
	`$D: hur går me armen // nu`
	$D: ***how*** *is your arm // now*
		time (e.g., onset of symptom)

här ('here')	`$P: här här här ja lite grann` *$P:* ***here here here*** *yes a little bit*	spatial state, presence (e.g., symptoms)
inte ('not')	`$P: nä de e de inte` *$P: no it's* ***not***	negative (e.g., negation)

lite ('a little, 'a bit', 'somewhat ')	$P: m / å de har blit **lite** sämre *$P: m / and it has become a **little** worse*	degree (e.g., description of symptoms)

Although *så* is common for all the participants, it is used more intensively by the native speakers (i.e., Swedish physicians and patients) than the non-Swedish physicians. The same is true of *då*. In analyzing the data, I observed that these adverbs are often used in constructions such as *då gör vi så* (literally 'in that case we'll do so'), *då är det så* (literally 'so in that case it is like this'), *då så* ('all right then'), *då ska vi se* ('let's see then'/'OK, let's see'), *då kan vi/du + verb* ('let's + verb'), *då tycker/tänker jag* ('in that case/then I think'), *om man säger så* ('you know'), etc. These constructions are used more commonly by the native speakers, probably due to their complexity. *Då* is also used in questions, and as was discussed in Chapter 5, the Swedish physicians use questions with *då* more often than the non-Swedish ones.

Concerning the **differences between physicians,** the non-Swedish physicians used such adverbs as *hur* ('how'), *mycket* ('much') and *också* ('also', 'too', 'as well') more than Swedish physicians.

Hur is used in questions inquiring about the quantity, length, or frequency of something, for example, time, treatment, medicines; it appears in constructions such as *hur + mycket/många + noun* ('how much/many + noun'), *hur + ofta/länge + verb* ('how often/long + verb'), and in inquiring about the state of someone's health, e.g., *hur + är/går det med + pron/noun* (literally 'how is it with + pron/noun', meaning 'how is/are + pron/noun). The fact that the non-Swedish physicians use *hur* more than the Swedish physicians can be explained by the number of wh-questions asked by the physicians in the corpora. As discussed in section 5.1, the non-Swedish physicians ask more wh-questions than the Swedish physicians, which is reflected in the frequency of *hur*.

The adjective *mycket* ('much') is also used more often by the non-Swedish compared to the Swedish physicians. As with the *jätte-* words discussed in the previous section, I would explain the use of *mycket* by a stronger tendency to hyperbolize, which is characteristic of the non-Swedish physicians and may be due to the fact that many of them come from overstatement cultures.

Consider the example below from the interaction between a physician from the former Yugoslavia and a Swedish patient:

Example 76. "Much much much role" (YuD19)

Talking about the situation in the former Yugoslavia

Speaker	Transcription	Translation into English
$P:	brytpunkten mellan dom två största religionerna ligger / där	*the breaking point between the two largest religions lies / there*
$D:	m de / e faktist spelar **mycke mycke mycke** roll / de e som du säjer / under den e	*m it / er actually plays **much much much** role / it is as you say / under that er*

Here, the physician needs to express a high degree of importance and does so by repeating the word *mycket* ('much').

Furthermore, due to their limited vocabulary other adverbs (e.g., *väldigt* ['enormously', 'tremendously'], *betydligt* ['considerably'], did not occur in the non-Swedish physicians' speech); as a result, the non-native speakers might be able to use only *mycket* and *jättemycket*

(‘very much’) to express what they mean.

The adverb *också* (‘also’, ‘too’, ‘as well’) is more common in the non-Swedish physicians’ speech than that of the Swedish physicians. I cannot provide a plausible explanation for this. However, it is not impossible that language competence plays a role here again. As well as using *också*, the Swedish physicians use *även* (‘also’, ‘too’, ‘even’), while the non-Swedish physicians use primarily *också*. The frequency lists confirm this. There are 25 occurrences of *även* produced by Swedish physicians in SweMedConsult, while only 6 occurrences produced by non-Swedish physicians are found in ICCMedConsult. Moreover, 5 out of these 6 occurrences of *även* are produced by a single Iranian physician (IraD8), who is one of the physicians who had spent the longest time in Sweden (about 14 years).

Apart from the already discussed *då* and *så*, the Swedish physicians use the adverbs *där* (‘there’), *här* (‘here’), *ju* (‘why’, ‘of course’, ‘as you know’) and *ut* (‘out’) more frequently than their non-Swedish counterparts.

In analyzing the transcriptions and the concordance lists, *där* and *här* are observed to be used for deictic purposes during the physical examination by both Swedish and non-Swedish physicians. However, the fact that the Swedish physicians use these adverbs more often might result from the fact that Swedish speakers use such demonstrative pronoun phrases as *det/den/de här/där* (‘this’/‘these’/‘those’) quite frequently, for example, *de här e ingenting djup va* (‘this is nothing deep, you know’); this appears to be another manifestation of the language competence factor (i.e., the non-Swedish physicians’ language problems).

Similarly, *ut* is more common for the Swedish physicians, primarily because they use more phrasal verbs, for example:

`$D: gallblåsan drar ihop sej` **`ramla ut`** `i gallgången`
$D: the gallbladder contracts ***falls out*** *in the bile duct*

`$D: bukspottkörtelsafterna kan` **`komma ut`** `som tömmer sej ut i tolvfingertarmen`
$D: pancreatic liquids can ***come out*** *and flow into the duodenum*

`$D: den` **`läker ut`** `sej själv`
$D: it ***heals*** *completely by itself*

The non-Swedish physicians’ use of *ut* in the corpus is limited to the phrases *skriva ut* (‘write’, ‘issue’, e.g., a prescription), *komma ut* (‘come out’), and *ser bra/bättre ut* (‘looks good’/‘better’).

An interesting difference between the Swedish and non-Swedish physicians is in the use of *ju* (‘of course’, ‘as you know’), which is more common in the Swedish physicians’ speech. I presume that, again, the complexity of usage of this adverb is a possible explanation. Looking at the use of *ju* by the physicians from different cultural groups (Table 73 below), we can observe that the Iranian physicians, who have spent more time in Sweden, use it more than the Hungarian and Mixed group physicians.

Table 73: Number of occurrences of *ju* ('of course, as you know') in the non-Swedish and Swedish physicians' speech (absolute numbers)

Physicians	**Number of occurrences of *ju***
Hungarian physicians	*0*
Iranian physicians	*83*
Mixed group physicians	*7*
Total non-Swedish physicians	90
Swedish physicians	277

Another explanation may also apply here. The function of *ju* in discourse is "as you know," for example:

```
$D: allså dom har ju andra faktorer
```
*$D: well they have other factors **as you know***

I presume that, independent of language competence, the non-Swedish physicians might be uneasy using *ju* because it could add an informal tone to the interaction (which might be more "acceptable" for the Swedish than the non-Swedish physicians). Furthermore, using ju with the meaning "as you know" presupposes that both physician and patient have common knowledge of something, for example:

```
$D: alla människor har ju ett unikt värde
```
*$D all people **as you know** have a unique value*

For the non-Swedish physicians, who come from a different culture than their patients, it might be difficult to claim this "common knowledge." However, more thorough research and more data are needed to support this hypothesis, as other factors (e.g., how well the physician and the patient are acquainted with each other) might influence the use of this adverb.

Concerning **patients**, no significant differences are observed.

6.5.3 Conjunctions

Table 74: Conjunctions (in alphabetical order) in PPM

Physicians					
Word	**Translation**	**Non-Swedish physicians**		**Swedish physicians**	
		freq	**rank**	**freq**	**rank**
No significant difference in frequencies					
å/och	*and*	27193	1	27953	1
innan	*before*	838	8	557	9
men	*but*	11502	3	11766	3
om	*if*	4704	5	5953	5
så	*so (that)*	3770	6	2889	7
utan	*but*	354	<10	522	10
än	*than*	451	10	835	8
More common for the non-Swedish physicians					
eftersom	*since, as*	677	9	174	<10
eller	*or*	9956	4	6962	4
More common for the Swedish physicians					
å/att	*to*	14854	2	25342	2
som	*like, as*	1579	7	3133	6

Patients					
Word	**Translation**	**Patients of non-Swedish physicians**		**Patients of Swedish physicians**	
		freq	**rank**	**freq**	**rank**
No significant difference in frequencies					
å/och	*and*	26819	1	26898	1
å/att	*to*	17137	2	19801	2
både	*both*	334	9	181	<10
eftersom	*since, as*	185	<10	407	10
eller	*or*	3339	5	4069	4
fast	*though, although*	223	10	452	9
innan	*before*	519	8	362	<10
men	*but*	13132	3	16184	3
om	*if*	3005	6	3525	6
som	*like, as*	1632	7	2170	7
så	*so (that)*	3413	4	4024	5
utan	*but*	519	8	497	8
än	*than*	334	9	452	9

Such conjunctions as *å/och* ('and'), *å/att* ('to'), *eller* ('or'), *men* ('but'), *om* ('if'), *som* ('as well as'), *så* ('so [that]') and *än* ('than') are among the 10 most frequently used conjunctions by both physicians and patients in both corpora.

The additive conjunction *och*, with its variant *å*, ranks highest for all participant groups, followed by *å/att*, which introduces narrative and consecutive subordinate clauses.

The conjunction *om* is used when the physician/patient needs to express a condition, for example, in constructions like *om det går bra* ('if it is fine [with you]'), *om de e så att du har nåra frågor* (literally 'if it is so that you have any questions'), *om de behövs* ('if needed'), etc.

Men is used to express something contrary to the expectations created by the previous utterance, for example, *men ja tycker/tror/menar* ('but I think/believe/mean'), *men då gör vi så här* (literally 'but then we will do like this' ['let's do it like this then']), etc.

The conjunction *så* is often used to express consequence, for example:

`$D: m` **`så`** `de här lappen ska du få av mej nu`
$D: mhm ***so*** *this paper you will get from me now*

It is also common in the constructions *så får vi se* ('so we will see'), *så har du* ('so if you have'), *så jag* + *verb* (e.g., *så jag gör mitt bästa* ['so I will do my best']), etc.

Concerning **the physicians**, *å/och, innan, men, om, så, utan* and *än* do not differ significantly in frequency in the speech of the two groups. I have already commented on the use of *å/att,*

men, om and *så*. *Innan, utan* and *än* are discussed below:

Example 77. Use of the conjunctions innan ('before'), *utan* ('but') *and än* ('than') *in medical consultations*

innan ('before')	$D: de de tar ett tag **innan** man får en sån grej *$P: it takes a while **before** one develops such a thing*	course of events (to indicate that one event occurs earlier than another) In medical consultation, it is often used in discussing the course of events in the treatment process, or the history of the disease
utan ('but')	$P: ja äter inte nån trombyl **utan** ja äter ALBYL *$P: I don't take any trombyl **but** I take ALBYL* $D: men / bara att man har gallstenar / behöver ju inte innebära att man måste opereras sig **utan** de e mer besvären som avgör de *$D: but / only that one has gallstones / doesn't mean that one must have surgery **but** it is more the troubles that determine this*	when the speakers want to eliminate one of two alternatives
än ('than')	$D: de är väl många som inte ä äldre **än** du *$D:I guess there are many who are not older **than** you*	used in comparisons

The conjunctions *eftersom* ('since', 'as') and *eller* ('or') are more commonly used by the non-Swedish Swedish physicians. In the case of *eftersom*, the difference is primarily due to the differences in the topics of interactions.

Eller is used to provide alternatives, as in *A eller B*, as well as an elicitation marker. As discussed in the previous chapter, questions with *eller* are asked more often by the non-Swedish than the Swedish physicians and more by female than male physicians. As can be observed from the transcriptions, the non-Swedish physicians often use *eller* when they have problems formulating their messages, for example:

Example 78. "Or such" (IraD6)

Talking about the patient's reason for coming

Speaker	Transcription	Translation into English
$D:	inget besvär me stickningar **eller** såna	*no problems with pricking **or** such*
$P:	nej	*no*

Å/att ('to') and *som* ('like', 'as') are more common in the Swedish physicians' speech. This can be explained by the language competence factor; the non-Swedish physicians' speech is syntactically simpler than that of the Swedish physicians. *Som* is used in explanatory comparisons, as in *A som B*; due to their language problems, it might be difficult for the non-Swedish physicians to find a suitable comparison, like the ones used by native speakers, for example:

$D: två muskeloljer ett / cirkulärt **som** en dammsugarslang

*$D: two muscle oils / circular **as** a vacuum tube*

$D: mellangärdet e ju **som** en bå + som ett valv
*$D: the diaphragm is like a bo + **like** an arch as you know*

No significant differences can be observed in the **patients**' use of conjunctions.

6.5.4 Feedback

Table 75: Feedback words (in alphabetical order) in PPM

Physicians					
Word	**Translation**	**Non-Swedish physicians**		**Swedish physicians**	
		freq	**rank**	**freq**	**rank**
No significant difference in frequencies					
ja/a/aa/ah/ jaa/jaja	*yes*	32606	1	30355	1
jaha/aha/ ha/hah	*I see, okay, is that so (positive)*	2932	6	2576	5
jo/jovisst/ jodå/jojo/ joo	*jo (similar to German doch) the contrastive yes*	677	<10	975	8
just	*exactly right*	838	10	522	10
nej/nä/ näeh/neej, nää/nänä	*no*	9956	4	9155	3
va	*feedback elicitor right*	1418	7	2228	6
visst, javisst	*sure, of course, I think*	1192	9	592	9
More common for the non-Swedish physicians					
hm/mhm	*similar to English*	4736	5	487	<10
m/mm	*similar to English*	22908	2	11522	2
okej	*okay*	13242	3	2959	4
precis	*exactly*	1321	8	453	<10
More common for the Swedish physicians					
ha	*okay that is the way things are*	32	<10	1323	7

Patients					
Word	**Translation**	**Patients of non-Swedish physicians**		**Patients of Swedish physicians**	
		freq	**rank**	**freq**	**rank**
No significant difference in frequencies					
hm/mhm	*similar to English*	594 /9	9	1266	10
ja/a/aa/ah/ jaa/jaja	*yes*	57534	1	56013	1
just	*exactly right*	594	9	949	<10
jaha/aha/ ha/hah	*I see, okay is that so (positive)*	4526	4	3797	4
jo/jovisst/ jodå/jojo/ joo	*jo (similar to German doch), the contrastive yes*	1781	6	2532	6
m/mm/ mhm	*similar to English*	25484	2	30470	2
nej/nä/ näeh/neej, nää/nänä	*no*	21997	3	19530	3
okej	*okay*	1669	8	2396	7
precis	*exactly*	1743	7	1085	<10
va	*feedback elicitor right*	3524	5	2667	5
More common for the patients of the Swedish physicians					
ha	*okay that is the way things are*	74	<10	1808	8
jaså	*oh, indeed, is that so*	556	10	1537	9

Most of the feedback words, such as *ja/a/aa/ah/jaa/jaja* (variants of 'yes'), *jaha/aha/ha* ('okay', 'is that so?' [positive]), *m/mm* (similar to English), *nej/nä/näeh/neej/nää/nänä* (variants 'no'), *okej* ('okay'), *va* (feedback elicitor 'right') are among the 10 most common feedback words for all participants.

The non-Swedish physicians are observed using more feedback words such as *hmm/mhm* and *m/mm*. I cannot provide a good explanation for this. However, in Swedish, the feedback word *hmm* is often used to show skepticism and *mhm* is used to indicate reflection. In other languages (for example, German), these expressions are neutral and used to indicate listening and understanding; the non-native speakers might experience more need to demonstrate to their patients that they are listening than the native speakers. Intensive use of *hmm/mhm* and

m/mm may therefore result from a transfer from the non-Swedish physicians' native languages. Compare the use of *mhm* in the examples below:

Example 79. Use of mhm

Non-Swedish physician (HuD1)	**Swedish physician (SweD6)**
The patient talks about her allergic reaction to Neoprene, which gave her an itch and blisters so she had to take Cortisone	The physician talks to the patient and recommends that she visit an occupational therapist. The patient says that she finds the occupational therapist a bit strange. The physician seems to be skeptical about what the patient is saying
$P: a / som ja har fått kli å blåsor å så *$P: yeah / that I have got itching and blisters and so* $D: < **mhm** > *$D: < **mhm** >* @ < head movement: nods > $P: fått kortison för de *$D: got cortisone for it* $D: m finns de / just nu nåra < förändringar på huden eller > *$D: m are there / right now any <changes on your skin or >*	$D: de här me å träffa: / NN som hon heter sjukgymnasten då som har hand om de här me fyss[37] [description of the training is left out] / men du behöver inte ens lova de utan du kan ju backa ur när du vill / så / men hon kan ju // också då utifrån sin kunskap ge dej råd om lämpli motionsform å *$D: about meeting / NN which is the name of the occupational therapist who takes care of fyss /* [description of the training is left out] */ but you don't even have to promise it but you can withdraw whenever you want to / so / but she can of course // also on the basis of her knowledge give you advice concerning suitable exercise types and* $P: hon verkar lite skum *$P: she seems a bit fishy* $D: **mhm m:** *$D: **mhm m:***

The non-Swedish physician uses *mhm* together with a nod to indicate that he has heard what the patient just said (the function of *mhm* here is similar to, for example, *ja*). On the contrary, the Swedish physician's use of *mhm* may be a way of showing her skepticism when the patient describes the occupational therapist as *skum* ('fishy').

The feedback word *okej* ('okay') is more common in the output of the non-Swedish physicians than of the Swedish ones. The non-native speakers seem to have adopted this English loan word as a way to give feedback until they have completely acquired the Swedish feedback words. *Precis* ('exactly') is also more commonly used by the non-Swedish than the Swedish physicians. Does this show the physicians' greater eagerness to agree with their patients compared to Swedish physicians? Or can it be traced back, like *okay*, to a loan of *precisely*?

In the example below, we can see how a Hungarian physician uses *precis*:

37. FYSS = Fysisk aktivitet i sjukdomsprevention och sjukdomsbehandling (physical activity in the prevention and treatment of disease).

Example 80. "Precisely" (HuD3)

Patient talking about his feelings concerning lifestyle changes after surgery

Speaker	Transcription	Translation into English
$P:	men han sa att detta kommer å ta tid // å du du får inte sätta dej å tycka synd om dej själv för [att de gör ont / du måste gå]	*but he said that this will take time // and you you mustn't sit down and feel sorry for yourself [because of the pain / you must walk]*
$D:	**< [javisst ja de e jätteviktit] precis >**	***[< of course yeah that's really important] exactly >***
@ < head movement: nods >		

The only feedback word used more often by Swedish physicians is *ha* ('okay', 'that is the way things are'). I presume that the non-Swedish physicians use *okej* in contexts where Swedes use *ha*, as the use of *ha* requires good Swedish competence. (I should add here that it is not common in language courses to teach how to give feedback in Swedish.)

Concerning the **patients**, ha and *jaså* ('indeed?', 'is that so?') are used more often by the patients of the Swedish physicians than the patients of the non-Swedish physicians. This may be explained by individual differences in giving feedback, as well as differences in the topics of interactions.

6.5.5 Interjections

Table 76: Interjections (in alphabetical order) in PPM

Physicians					
Word	Translation	Non-Swedish physicians		Swedish physicians	
		freq	rank	freq	rank
No significant difference in frequencies					
hej	*hello, hi*	934	3	766	1
More common for the non-Swedish physicians					
aj	*oh, ow, ouch*	902	4	0	<10
oj	*oops, oh*	1095	2	70	3
tack	*thank you*	1579	1	278	2

Patients					
Word	Translation	Patients of non-Swedish physicians		Patients of Swedish physicians	
		freq	rank	freq	rank
No significant difference in frequencies					
hej	*hello, hi*	964	3	949	2
herregud	*good heavens*	111	5	226	3
More common for the patients of the non-Swedish physicians					
aj	*oh, ow, ouch*	1415	2	0	<10
oj	*oops, oh*	519	4	90	5
tack	*thank you*	2077	1	1673	1

Hej ('hello', 'hi') and *tack* ('thank you') are commonly used by for all participants in both corpora, which is not surprising, as it is normal for the participants to greet each other at the beginning and to express gratitude at the end of the medical consultation.

Concerning the **physicians**, all interjections but *hej* are more intensively used by the non-Swedish than the Swedish physicians. As has been mentioned above (see 6.5), the non-Swedish physicians use more interjections in general, which may indicate that they are more openly emotional than the Swedes. Analyzing the interactions more closely, I explain the

differences in the following ways.

The topics of interactions and the individual speakers' communicative behavior play a key role, as when a German doctor imitates his patient by saying *aj aja* when she expresses pain during a physical examination. Consider also Example 18 "Ouch, it hurts," in which a Russian physician uses the interjection when she has word-finding problems, as well as in an attempt to make her recommendation more expressive.

Another factor may be cultural, namely the presumed higher emotionality of the non-Swedish physicians compared to the Swedish ones. In the example below, the Russian physician openly expresses her surprise at and admiration of how well her 89-year-old patient looks:

Example 81. "You look good" (RusD18)

Reading the file and talking about the patient's age

Speaker	**Transcription**	**Translation into English**
$D:	okej m // de e kanske mindre bra me propavan för dej e / du e åtti [<1 åttinie >1 år **oj >2] oj oj** du e <2 åttinie >2 år de va / du ser <3 väldit bra ut för att vara <4 åttinie >4 >3	*okay m // it is maybe not good for you to take propavan er // you are eighty [<1 eighty-nine >1 years old **oj >2 oh my**] it was / you look <3 very good to be < 4 eighty-nine >4 >3*
@ <1 SO: åttionio/eighty-nine >1 @ <2 SO: åttionio/eighty-nine >2 @ <3 gaze: looking at M (the patient's daughter) >3 @ <4 chuckling >4		
$P:	[(< åttinie > år gammal >]	*[< eighty-nine >years old >]*
@ < SO: åttionio/eighty-nine >		
$P:	ja ja ska bli nitti ja ska bli nitti i å	*yeah I'm turning ninety I'm turning ninety this year*

Complimenting the patients and using interjections to express emotions are not observed in the Swedish physicians' speech. This example shows a somewhat more emotional way of talking to the patient, which might be related to the physician's cultural background.

It is interesting that *tack* is used more by the non-Swedish physicians than the Swedish ones. This contradicts a common claim about Swedish *tacksamhet* ('gratitude') and the frequency of *tackande* ('thanking'), mentioned by Allwood (1999), unless the behavior has been "overlearned" by the non-Swedish physicians, as a salient feature of the Swedish context.

Analyzing the recorded interactions, we can see that the Swedish physicians often use the verb *tacka* ('to thank'), while few non-Swedish physicians do so:

$D: bra de **tackar** vi för
*$D: good, we **thank** you for that*

In addition, the Swedish physicians use the construction *tack ska du ha* ('thanks'), while the non-Swedish physicians are more likely to say *tack så (jätte)mycket* ('thank you very much [indeed]'). This might be explained by lack of language competence (i.e., the greater complexity of the construction *tack ska du ha* compared to *tack*); in the latter case *tack så jätte mycket* might be considered to be more polite by the non-native speakers. In addition, using *jätte(mycket)* may be a sign of the above-mentioned, possibly cultural tendency to hyperbolize.

Concerning the **patients**, the differences tend to follow the same patterns as the differences between physicians. The only interjection that is used by the patients but not the physicians is *herregud* ('good heavens'), which is used to express surprise.

6.5.6 Nouns

Table 77: Nouns (in alphabetical order) in PPM

Physicians					
Word	**Translation**	**Non-Swedish physicians**		**Swedish physicians**	
		freq	**rank**	**freq**	**rank**
No significant difference in frequencies					
besvär(en)	*(the) trouble(s)*	1031	8	1253	8
gång(en/er(arna))	*(the) time(s), once*	3029	1	2263	1
fall(et)	*(the) case(s), way*	1095	7	1149	10
medicin(er/na)	*(the) medicine(s)/ medication*	1837	3	1462	5
tid(en/erna)	*(the) time(s)*	1998	2	1880	3
operation(en/erna)	*(the) surgery(-ies)/ (the) operation(s)*	1740	4	1323	6
tablett(en/er/na)	*(the) tablet(s)*	967	10	1601	4
More common for the non-Swedish physicians					
fråga(n)/-or	*(the) question (s)*	999	9	418	<10
hjärta(t)	*(the/your) heart*	967	10	278	<10
problem(et)	*(the) problem(s)*	1643	5	383	<10
år(et/ena)	*(the) year(s)*	1482	6	661	<10
More common for the Swedish physicians					
inflammation	*inflammation*	226	<10	1218	9
mage(n)	*(the) stomach, abdomen, belly*	741	<10	2054	2
tarm (en/arna)	*(the) intestine(s)*	161	<10	1288	7

Patients					
Word	**Translation**	**Patients of non-Swedish physicians**		**Patients of Swedish physicians**	
		freq	**rank**	**freq**	**rank**
No significant difference in frequencies					
dag(en/ar(na)	*(the) day(s)*	779	7	859	6
doktor(n/er(na)	*(the) doctor (s)*	853	6	1401	3
gång(en/er(na))	*(the) time(s), once*	2597	2	3029	1
fall(et/en)	*(the) case(s), way*	853	6	859	6
läkare(n/na)	*(the) physician(s)*	890	5	1401	3
mage(n)	*(the) stomach, abdomen, belly*	742	8	769	7
medicin (en/er(na))	*the) medicine(s)/ medication*	519	10	633	8
tid(en/er(na)	*(the) time(s)*	1669	3	995	4
operation(en/er(na)	*(the) surgery(-ies)/ (the) operation(s)*	631	9	362	10
par	*pair(s)*	371	<10	542	9
tablett(en/er(na))	*(the) pill(s)*	519	10	904	5
år(et/en(a)	*(the) year(s)*	2634	1	2034	2
More common for the patients of the non-Swedish physicians					
problem(et/en)	*(the) problem(s)*	853	6	271	<10
värk(en)	*(the) pain(s)*	964	4	226	<10

The nouns used reflect primarily the structure and purpose of the medical consultation as a social activity and the topics of the interactions. Such nouns as *gång* ('time', 'once'), *fall* ('case', 'way'), *medicin* ('medicine', 'medication'), *tablett* ('tablet'), *operation* ('surgery', 'operation') and their inflected forms are among the 10 most common ones produced by both

physicians and patients in the two corpora.

The need to indicate the time and frequency of, for example, taking pills, number of treatments, occurrence of symptoms, etc., motivates the use of *gång*, for example:

`$D: en` **`gång`** `e på tre månader eller`
$D: ***once*** *in three months or*

`$D: har du blivit opererad flera` **`gånger`** `eller en` **`gång`**
$D: have you had surgery many ***times*** *or* ***once***

In addition, *gång* is used in constructions like *första/andra gången* ('first/second time'), *med en gång* ('at once'), *nästa/varje/nån gång* ('next/every/some time'), etc.

The noun *fall* ('case', 'way') is used to talk about the patient's situation, *as in i ditt fall* ('in your case'), but it is primarily used in the constructions *i alla fall* ('[well] anyway') and *i så fall* ('in this case'), which are common in spoken Swedish.

The nouns *medicin* ('medicine', 'medication'), *tablett* ('tablet') and *operation* ('surgery', 'operation') are used to talk about treatment and medical history.

The physicians in both groups use such nouns as *besvär, gång, fall, medicin, tid, operation* and *tablett* at similar frequencies.

The nouns *fråga* ('question'), *hjärta* ('heart'), *problem* ('problem'), *år* ('year') and their inflected forms are more common in the speech of the non-Swedish compared to the Swedish physicians.

An interesting observation can be made concerning *fråga*. When one analyzes the concordance lists, one finds that the non-Swedish physicians introduce their questions with constructions such as *jag vill ställa en fråga till* ('I would like to ask one more question), *jag har en fråga till* ('I have one more question'), which Schegloff (1980) calls *preliminaries*. Their function is to introduce the questions that follow. Preliminaries are used for different reasons, including when the question is sensitive ("pre-delicates"), when the speaker needs time to formulate the question, or when leading up to the point, for example, "now the point is" (Schegloff, 1980). They are also known as pre-questions, pre-announcements, pre-offers, and pre-requests, depending on the context.

A total of 15 occurrences of "pre-questions" are presented in the ICCMedConsult corpus, compared to only one in the SweMedConsult corpus.

Table 78: Preliminaries

Preliminaries	**Translation**	**Non-Swedish physicians**	**Swedish physicians**
det är frågan, då är min fråga	*this is the question, then my question is*	2 (HuD1, GerD12)	0
får jag fråga (dig)	*may I ask (you)*	6 (HuD3, HuD4, RusD18)	0
jag skulle (vilja) fråga dig	*I would like to ask you*	2 (IraD7)	0
jag vill gärna fråga dig bara en sak till	*I would like to ask you just one more thing*	1 (HuD3)	0
fårlåt mig men jag måste fråga dig två saker till	*I am sorry/excuse me but I must ask you two more things*	1 (HuD3)	0
då ville jag fråga ytterligare någonting	*I would like to ask you something more*	1 (IraD6)	0
jag glömde fråga	*I forgot to ask*	1 (IraD6)	0
jag undrar	*I wonder*	1 (YugD19)	1 (SweD3)
Total		**15**	**1**

I think that using preliminaries is a strategy the non-Swedish physicians apply to win time to formulate the following question. Moreover, the use of preliminaries might reflect greater formality in the physician-patient relationship in intercultural compared to Swedish medical consultations. However, individual differences in questioning behavior should not be underestimated either.

The non-Swedish physicians use the word *problem* more often than the Swedish physicians. This is probably because it is an international word: cf. English *problem*, German *Problem*, Russian *problema*, Hungarian *probléma*.

År and *hjärta* and their inflected forms are more commonly used by the non-Swedish physicians, which I explain by the differences in the topics discussed in their consultations.

Given that the majority of consultations included in the SweMedConsult corpus are surgery consultations, it is not surprising that such words as *inflammation* (‘inflammation’), *mage* (‘stomach’, ‘abdomen’, ‘belly’), *tarm* (‘intestine’) and their inflected forms are more common in the output of the Swedish physicians.

No significant differences in frequencies were observed in the **patients**’ speech for any nouns except *problem* and *värk* (‘pain’) and their inflected forms (due to the topics of the interactions).

6.5.7 Numerals

Table 79: Numerals (in alphabetical order) in PPM

Physicians					
Word	**Translation**	**Non-Swedish physicians**		**Swedish physicians**	
		freq	**rank**	**freq**	**rank**
No significant difference in frequencies					
andra	*second*	644	4	278	4
fem	*five*	580	5	209	5
först, första	*first*	644	4	139	6
sex	*six*	516	7	313	3
tre	*three*	1289	2	940	1
More common for the non-Swedish physicians					
fyra	*four*	773	3	209	5
noll	*zero*	548	6	35	<10
två	*two*	1933	1	627	2

Patients					
Word	**Translation**	**Patients of non-Swedish physicians**		**Patients of Swedish physicians**	
		freq	**rank**	**freq**	**rank**
No significant difference in frequencies					
andra	*second*	482	6	180	6
fyra	*four*	890	3	226	5
sex	*six*	297	7	316	3
två	*two*	1855	1	995	1
tre	*three*	1150	2	588	2
More common for the patients the non-Swedish physicians					
fem	*five*	766	5	271	4
först, första	*first*	816	4	271	4
noll	*zero*	482	6	45	<10

The table shows that the majority of numerals used in the medical consultations in both corpora are cardinal; they are used to refer to, for example, the number of tablets to take (*två tabletter* ['two tablets]), hours/minutes/months (*du kan ta i sex månader* ['you can take six months']), dosage (*två kalium* ['two potassium [tablets]']), etc. The ordinal numerals that appear are *först* ('first') and *andra* ('second'). They often occur in combination with the noun *gång* ('time'), for example, *första/andra gången* (talking about hospital visits), as well as *första behandlingen* ('the first treatment'), *första veckan* ('the first week'), etc. The ordinal numerals are also used to talk about the sequence of events:

`$D: vi gör **först** en röntgen`
*$D: **first** we do an X-ray*

The significant differences in the use of numerals are due to the topics discussed rather than any other factors.

6.5.8 Own communication management (OCM)

I have introduced the notion of OCM in sections 4.3.4 and 6.4. To start with a general picture of OCM distribution, hesitation sounds are more common than interrupted words in both corpora:

Table 80: Types of OCM words (in PPM): comparison of non-Swedish and Swedish physicians and patients of non-Swedish and Swedish physicians

OCM type	Non-Swedish physicians	Swedish physicians	Patients of non-Swedish physicians	Patients of Swedish physicians
Hesitation sounds	40790	9016	20439	15145
Interrupted words	3512	2020	3190	2984

Hesitation sounds are over-represented in the intercultural medical encounters compared to the Swedish medical consultations. A significant difference in the use of hesitation sounds can be observed between the non-Swedish and the Swedish physicians and between their respective patients. Interrupted words are produced significantly more by the non-Swedish physicians than the Swedish physicians, while no significant difference can be observed in the patients' speech in the two corpora.

The fact that intercultural medical consultations are characterized by more hesitation sounds and interrupted words can be explained by the physicians' use of Swedish as a foreign language; they have problems formulating their messages. At the same time, the Swedish patients, as mentioned above, attempt to speak more slowly to help the non-Swedish physicians understand. This might result in their using more hesitation sounds than they would in interactions with native speakers.

Table 81: OCM (in alphabetical order) in PPM

Physicians					
Word	Translation	Non-Swedish physicians		Swedish physicians	
		freq	rank	freq	rank
More common for the non-Swedish physicians					
e (eh)	*er, um, uh*	36988	1	8424	1
ö	*er, um, uh*	3254	2	35	3

Patients					
Word	Translation	Patients of non-Swedish physicians		Patients of Swedish physicians	
		freq	rank	freq	rank
More common for the patients of the non-Swedish physicians					
e (eh)	*er, um, uh*	19883	1	13834	1
ö	*er, um, uh*	631	2	181	3

The hesitation sounds *e/eh* ('er') and *ö* ('er') are produced by all the participants, but they are considerably more common in the non-Swedish physicians' and their patients' interactions. The example below illustrates hesitation sounds and self-interrupted words in a non-Swedish physician's speech (adapted from Allwood and Berbyuk, 2006):

Example 82. "Breathing problem" (HuD4)

Talking about physical condition

Speaker	Transcription	Translation into English
$D:	vid lätt ansträngning eller vid större ansträngning inget problem	*in case of light exertion or more exertion no problem*
$P:	nej	*no*
$D:	**ingen <1 anf+ >1 e <2 andfådd+ >2 e / <3 and+ >3 // andningsproblem**	***no <1 breathl+ > er <2 breathless+ >2 er / <3 breath+ >3 // breathing problems***
@ <1 cutoff: andfåddhet/breathlessness >1 @ <2 cutoff: andfåddhet/breathlessness >2 @ <3 cutoff: andningsproblem/breathlessness/breathing problem >3		
$P:	< nej >	< *no* >
@ < ingressive >		

In the example above, the physician is apparently having difficulties recalling and pronouncing the word. The OCM word e, the pause // and the self-interrupted words *anf* + ('breathl + '), *andfådd* + ('breathless + ') and *and* + ('breath + ') indicate this. Finally, the physician chooses another word instead of the target one (i.e., *andningproblem* ['breathing problems'] instead of *andfåddhet* ['breathlessness']).

6.5.9 Prepositions

Table 82: Prepositions (in alphabetical order) in PPM

Physicians					
Word	Translation	Non-Swedish physicians		Swedish physicians	
		freq	rank	freq	rank
No significant difference in frequencies					
av	*of*	2771	6	3725	6
från	*from*	999	<10	940	8
i	*in, at*	9054	2	10617	2
med	*with*	8023	3	8285	3
mot	*towards again, for*	1289	9	870	9
till	*to, till*	5638	5	5396	5
under	*under*	1160	10	661	10
More common for the non-Swedish physicians					
efter	*after*	1965	8	1044	7
More common for the Swedish physicians					
för	*for*	5780	4	8215	4
om	*round, around*	2481	7	3725	6
på	*on, at*	9988	1	12741	1

Patients					
Word	Translation	Patients of non-Swedish physicians		Patients of Swedish physicians	
		freq	rank	freq	rank
No significant difference in frequencies					
av	*of*	1558	7	1447	7
för	*for*	9014	3	10036	3
i	*in, at*	12464	1	10759	2
med	*with*	6900	4	6239	4
om	*round, around*	1484	8	2080	6
på	*on, at*	10201	2	12025	1
till	*to, till*	2968	5	3797	5
utan	*without*	927	9	814	8
över	*over*	705	10	542	10
More common for the patients of the non-Swedish physicians					
efter	*after*	1781	6	769	9

All the prepositions except *från* ('from'), *mot* ('towards', 'against,' 'for'), *utan* ('without') and *över* ('over') are among the 10 most common ones for all the participants, both

physicians and patients.

Concerning the **physicians**, no significant differences in the frequencies of *av*, *från*, *i*, *med*, *mot*, *till* and *under* can be observed.

The non-Swedish physicians use *efter* (‘after’) more than the Swedish physicians while the Swedish physicians use *för* (‘for’), *om* (‘if’) and *på* (‘on’, ‘at’) more than the non-Swedish physicians. Similarly, the **patients** of the non-Swedish physicians use *efter* more than the patients of the Swedish physicians. The preposition *efter* is the only one that is more common in intercultural than Swedish medical consultations. I would explain this by the differences in the contents of the interactions. *Efter* describes a temporal relationship, and the greater variety of consultation types in ICCMedConsult may result in more use of this preposition when talking about, for example, a patient’s state of health before and after treatment. Swedish physicians’ more extensive use of such prepositions as *på, för,* and *om* may depend upon the topics discussed in their consultations.

The **patients** show no significant differences in frequencies for any prepositions except *efter*, which is more frequently used by the patients of the non-Swedish physicians. This is similar to the situation with physicians and may be explained by the content and by accommodation in interactions.

6.5.10 Pronouns

Table 83: Pronouns (in alphabetical order) in PPM

Physicians					
Word	**Translation**	**Non-Swedish physicians**		**Swedish physicians**	
		freq	**rank**	**freq**	**rank**
No significant difference in frequencies					
du, dej, din(a)/ditt	*you, your, yours*	52002	2	50231	2
som	*who, whom, that, which*	6444	7	8111	8
nånting, nå(go)n, nå(go)t, nåt, nå(g)ra	*someone, somebody, something*	10826	5	9573	7
va(d)	*what*	5091	9	3725	9
More common for the non-Swedish physicians					
jag/ja, mej, min/mitt, mina	*I, me, my, mine*	16561	3	15108	3
vi, oss, vår(a)/t	*we, us, our, ours*	15304	4	11487	6
ingen/inget, inga, ingenting	*nobody, no one, nothing, no*	4607	10	2820	10
More common for the Swedish physicians					
de(t)/den, de/dem/ dom, denna/ (e)/detta	*it, they, this, that, these, those*	67178	1	82292	1
en, ett	*one*	10504	6	13089	5
man	*one*	6218	8	14620	4

Patients					
Word	**Translation**	**Patients of non-Swedish physicians**		**Patients of Swedish physicians**	
		freq	**rank**	**freq**	**rank**
No significant difference in frequencies					
jag/ja, mej, min/mitt, mina	*I, me, my, mine*	70999	2	74141	2
en, ett	*one*	11611	3	10533	3
som	*who, whom, that, which*	5861	4	5380	8
man	*one*	5527	6	6510	7
va(d)	*what*	4303	9	4204	9
ingen/inget, inga, ingenting	*nobody, no one, nothing, no*	3376	10	3436	10
More common for the patients of non-Swedish physicians					
de(t)/den, de/dem/ dom, denna/ (e)/detta	*it, they, this, that, these, those*	83649	1	76899	1
More common for the patients of the Swedish physicians					
du, dej, din(a)/ditt	*you, your, yours*	5750	5	8273	4
han, honom, hans	*he/she, him/ her, his/hers*	4377	8	8228	5
nånting, nå(go)n, nå(go)t, nåt, nå(g)ra	*someone, somebody, something*	4785	7	7007	6

Only *vi* ('we') and *han, honom, hans* ('he') and their inflected forms are not among the 10 most common pronouns for all the participants. The pronoun *det/den, de/dem/dom, denna/(e)/ detta* ('it', 'they', 'this', 'that', 'these', 'those') ranks highest. The personal pronoun *du* ('you'), with its inflected forms, ranks next highest for the physicians, which can be explained by their need to address the patients; for the patients, on the other hand, the pronoun *jag* ('I') and its forms ranks second as the patients talk about themselves in the consultations.

The fact that *vi* is among the most common pronouns for the physicians but not the patients can be explained by the influence of activity roles. The physicians use *vi* to refer to "physician + patient," "physician + patient + other personnel" or "medical personnel," which

is uncommon for the patients to do:

$D: **vi vi** / lindra dina besvär ett tag
*$ D: **we we** / relieve your troubles for a while*

Concerning the **physicians**, the non-Swedish physicians use *jag*, *vi, ingen* and their inflected forms more while the Swedish physicians use *det* and its inflected forms, *en, ett* ('one') and *man* ('one').

Differences in the frequencies of *jag* and *vi* between the physicians may depend upon a number of factors. Both Swedish and non-Swedish physicians use *jag* to comment on what they are going to do in consultations, for example:

$D: **ja** ska bara lyssna lungorna på dej
*$D: **I** will just listen to your lungs*

It is interesting that *vi* is used more often by the non-Swedish physicians than the Swedish physicians. Does this indicate that the non-Swedish physicians have a more collectivistic view? It would be difficult to find proof of this hypothesis in the data.

Swedish physicians use *det* and its inflected forms more than the non-Swedish physicians; use of this pronoun is a typical sign of a fluent Swedish speaker.

As discussed in section 5.2, the Swedish physicians use *man* ('one') more than the non-Swedish physicians, which probably stems from cultural differences. It reflects the typically Swedish indirect, distanced way of talking. Language competence may be relevant here as well.

I cannot explain the differences in the use of *en/ett* and *ingen/inget.* First language influence is one possible explanation. It may be difficult for non-Swedes to know when *en/ett* should be used, which may result in their not using these forms.

The **patients** of the Swedish physicians seem to address their physicians more with *du* ('you') than the patients of the non-Swedish physicians. In the concordance program, such constructions as *vet du* ('you know'), *ser du* ('you see'), *jaha du* ('aha you') are found to be more common in the SweMedConsult corpus than in the ICCMedConsult corpus, for example:

$P: skit me gamla käringen **ser du**
*$P: I'm just a crappy old hag **you see***

This may depend upon differences in power distance and show that the patients are more formal in their interactions with the non-native speakers. Other differences may be due to the topics of the interactions.

6.5.11 Verbs

Table 84: Verbs (in alphabetical order) in PPM

Physicians					
Word	**Translation**	**Non-Swedish physicians**		**Swedish physicians**	
		freq	**rank**	**freq**	**rank**
No significant difference in frequencies					
bli(r), blev, blivit	*become(s), became, become*	5220	7	5396	9
få(r), fick, fått	*get(s), got, got may/might*	7604	5	9016	5
gör(a)/s, gjordes, gjort	*do(es), did, done*	7314	6	7415	6
gå(r), gick, gått	*go(es), went, gone*	3834	<10	5222	10
ha(r), hade, haft	*have/has, had, had*	23778	2	23427	2
kan, kunde, kunna	*can, could*	13274	3	12393	3
komma, kommer, kom, kommit	*come(s), came, come*	4382	9	4873	<10
se(r), såg, sett	*see(s), saw, seen*	4285	10	5604	8
ta(s)/r, tog, tagit/tatt	*take(s), took, taken*	4543	8	7067	7
ä(r), va(r)/a, varit, vart	*be, is, was, were, been*	35732	1	36725	1
More common for the non-Swedish physicians					
ska(ll), skulle	*shall, should will, would*	8538	4	19826	4

Patients					
Word	**Translation**	**Patients of non-Swedish physicians**		**Patients of Swedish physicians**	
		freq	**rank**	**freq**	**rank**
No significant difference in frequencies					
bli(r), blev, blivit	*become(s), became, become*	5342	7	3933	<10
gör(a)/s, gjordes, gjort	*do(es), did, done*	6677	5	8183	3
ha(r), hade, haft	*have/has, had, had*	29639	2	28165	2
kan, kunde, kunna	*can, could*	7159	4	7007	6
komma, kommer, kom, kommit	*come(s), came, come*	3487	10	4069	10
ska(ll), skulle	*shall, should will, would*	6603	6	7414	4
ta(s)/r, tog, tagit/tatt	*take(s), took, taken*	4451	8	4250	9
ä(r), va(r)/a, varit, vart	*be, is, was, were, been*	39543	1	38879	1
More common for the patients of the non-Swedish physicians					
få(r), fick, fått	*get(s), got, got may/might*	8384	3	6148	7
More common for the patients of the Swedish physicians					
gå(r), gick, gått	*go(es), went, gone*	3969	9	7052	5
vet(a), visste, vetat	*know(s), knew, known*	3450	<10	4792	8

To start with similarities, the verbs *är* (‘be’), *få* (‘get’), *göra* (‘do’), *ha* (‘have’), *kan* (‘can’), *skall* (‘shall’), *ta* (‘take’) and their inflected forms are among the 10 most common verbs for all participants. Among the **physicians**, the only significant difference can be observed in the frequency of *skall, skulle* (‘shall’, ‘should’, ‘will’, ‘would’). For the **patients**, the verb *få*, and its inflected forms, is more frequent in the speech of the non-Swedish physicians’ patients while *gå* (‘go’) and *veta* (‘know’) are produced more frequently by the patients of the Swedish physicians. The analysis of the concordance lists shows that the above-mentioned differences are due to the topics of the various interactions.

6.6 Summary of Chapter 6

In this chapter, I have presented an overall analysis and comparison of intercultural and Swedish medical consultations. The analysis has resulted in a number of observations concerning similarities and differences, which I will briefly summarize and discuss below. In some cases, though, I was unable to provide good explanations of the phenomena observed.

To start with **similarities**, they are primarily due to the influence of the activity. The fact that both intercultural and Swedish medical consultations are characterized by frequent use of pronouns, adverbs and feedback is a result of this influence. The pronouns *du* ('you') and *jag* ('I') and their inflected forms are used by the physicians and patients as forms of address and when talking about personal experiences. Adverbs are necessary to denote time and place, and feedback to give answers and show attention and understanding. These parts of speech are tools used by the participants to fulfill the purpose of the medical consultation. Similarities can also be observed in some of the most common words. For example, the adjectives *bra* ('good', 'fine') and *dålig* ('bad', 'poor') and their inflected forms are common in both intercultural and Swedish-only medical consultations, as they are used to evaluate the patient's state of health, symptoms, etc., which is a necessary part of the activity.

Some words are commonly used by the physicians, but not the patients. For example, *normal* is used by the physicians, but not patients, as it is the physician and not the patient who has the competence to evaluate something as being "normal."

The **differences** observed among groups are due to the following factors:

I. **Topics of interactions**. Different topics in the interactions result in differences in word length, Vocab values and some of the most common words representing each part of speech. There is a greater variety of consultation types in ICCMedConsult.

II. **Using Swedish as a foreign language and cultural differences:**

- More pauses and more OCM are produced by the non-Swedish physicians and their patients compared to the Swedish physicians and their patients. This indicates that the non-Swedish physicians need more time to formulate their messages. Hesitation sounds and interrupted words are the results of the problems they have in this regard. The fact that the patients of the non-Swedish physicians also pause more than the patients of the Swedish physicians might indicate how patients adjust to their physicians.
- The conjunction *eller* ('or') is used more by the non-Swedish physicians than the Swedish ones, because the former ask more questions with eller than the latter (see section 5.1).
- Questions with "preliminaries" (Schegloff, 1980) are used more by the non-Swedish than the Swedish physicians, probably so they can take extra time to formulate their questions. As a result, the former use the noun *fråga* ('question') more than the latter.
- The more intensive use of feedback by the non-Swedish physicians may be motivated by their need to show that they are listening and that they understand, to reassure their patients, who might be critical or worried because of the physician's possible lack of linguistic competence. This also confirms the findings concerning the use of repetitions and reformulations (i.e., they are used more by the non-Swedish physicians, see section 5.3).

- The greater number of conjunctions and prepositions used by the Swedish physicians reflects their more complex syntax.
- Some words are more common in the non-Swedish physicians' speech because they are international words, such as *problem*, *okay*. The frequency of *färdig* ('ready', 'finished') is because a single German physician uses it like German *fertig*, and *precis* ('exactly') may be used for similar reasons. The international feedback word *okay* is used more than the Swedish equivalent *ha*, which has the same function.
- Some words are used more commonly by native speakers than non-native ones because they use certain specific constructions that the non-native speakers do not use, probably due to language competence; the adverbs *då* ('then'), *där* ('there'), *här* ('here'), and *ut* ('out') are among them.
- The adverb *ju* ('of course', 'as you know') is used more by the Swedish physicians than the non-Swedish ones. Both complexity of use and a possible problem for non-native physicians to claim common knowledge with a patient from different cultural background may have an impact here.
- Increased use of adjectives by the non-Swedish physicians may be a sign of a greater tendency to evaluate. Furthermore, the intensive use of *bra* ('good', 'fine'), *mycket* ('much') and *jätte-* words may be a sign of overstatement cultures. The Swedish physicians use these words less. However, it may also be a consequence of problems expressing quantity, degree, or extent, etc.
- Interjections are used more often by the non-Swedish physicians than by the Swedish physicians. This may indicate that intercultural medical consultations are more emotional than Swedish-only ones.

III. **A more personal, polite and, at the same time, more formal attitude of non-Swedish physicians in communication with their patients is manifested in the following findings:**

- Swedish physicians use the impersonal pronoun *man* ('one') more often than the non-Swedish physicians. This reflects their more neutral way of talking. However, the language factor may be involved here as well, namely non-Swedish physicians' lack of knowledge of how to use this pronoun (see section 5.2. for the analysis of man).
- The patients of Swedish physicians use *du* ('you') more to refer to their physicians than the patients of the non-Swedish physicians, primarily in constructions like *ser du* ('you see'), *vet du* ('you know'), *jaha du* ('aha you'). This might depend upon power distance in interactions: a more formal attitude on the part of the non-Swedish physicians and the patients' greater care in talking to a non-native speaker.

As one can see, the activity of medical consultation, the use of Swedish as a foreign language and cultural factors influence communication between non-Swedish physicians and their Swedish patients. However, more data and a more detailed analysis of some of the findings obtained here are needed before further conclusions can be drawn.

Chapter 7: Some observations on communication between non-Swedish physicians and their Swedish colleagues

In medicine, the road is long for us all, but for the foreign medical graduate it is inevitably more winding and rough. It is our obligation to not abandon our colleagues along the way, but to seek to ease their journey with small, personal gestures and larger, administrative measures. While they tend out society's sick, we must not deny them their own bruises that often lie just beneath the surface. It is only then as physicians we can truly call ourselves healers.
(Srivastava and Green, 2004, p. 644)

In the "Communication and Interaction in Multicultural Health Care" project, we focus not only on communication between non-Swedish physicians and their Swedish patients, but also on communication between non-Swedish physicians and their colleagues. This chapter presents a concise summary of the analysis of intercultural communication between non-Swedish physicians and their Swedish colleagues, in an attempt to provide a more comprehensive picture of the non-Swedish physicians' communication in the Swedish health care system than if we had only considered communication between physicians and patients.

As I have mentioned before, this chapter is partially a summary of results that have already been presented and published in a number of articles (Berbyuk et al., 2003; Allwood et al., 2004; Allwood et al., 2005; Berbyuk et al., 2006; Allwood et al., 2007). In addition, I provide a more detailed analysis of data that have not been published before (the articles mentioned above are based primarily on the responses to the questionnaires), namely analyses of recorded interactions between non-Swedish physicians and other medical personnel during work meetings, and of the observations and interviews.

7.1 Methods, participants and data

As with the analysis of physician-patient communication in this thesis, I follow Allwood's activity based communication approach to analyze physician-colleague communication; I combine the data from the interviews, questionnaires, observations and recordings of work meetings, in which the non-Swedish physicians participate and communicate with their Swedish colleagues. The excerpts from the interviews and the questionnaire data are supported with examples from the transcriptions of the recordings.

The interview and questionnaire data used for the analysis and the information about the participants involved have already been presented in Chapter 3 and in Appendix A and D. In spite of the variety of cultural backgrounds the non-Swedish physicians represent, the main interests in this chapter are the characteristics of the non-Swedish physicians as a group and gender-related issues. Consequently, nationality will only be presented when it is relevant in explaining the results.

The Swedish health care respondents include the following six groups: physicians, nurses, assistant nurses, physiotherapists, and care assistants and laboratory assistants.

The questionnaires targeting the non-Swedish physicians and the Swedish health care personnel contain 7 and 11 questions, respectively, concerning the respondents' views on

communication (see Appendix A). A similar approach to that applied in the analysis of the questionnaire on physician-patient communication was used.

The database analyzed is presented in Table 85. The table includes information about which non-Swedish physicians participated in the recordings selected for the analysis, the recorded activity number, type and recorded time. All recordings are video recordings. Similar recording and transcribing procedures were used as for the medical consultations. All the participants involved gave their consent to be recorded.

Table 85: Overview of recordings of work meetings and hospital rounds

Participant code *Non-Swedish physician(s) who participated in the corresponding recording(s)*	**Recorded activity number/type**	**Recorded time**
IraqD14	IraqD14 surgery round 1	10 min
	IraqD14_surgery round 2	14 min
GerD13 + IraqD14	candidate round (surgery)	2 hrs 19 min
GerD13	surgery round 3	58 min
PolD17	neuro round	12 min
IraD6	rehabilitation round	2 hrs 46 min
	rehabilitation team	8 min
Total recorded time		**6 hrs 47 min**

Seven work meetings were selected for the study out of the nine recorded for the project. Two recorded meetings were excluded due to the poor quality of the recording. The total recording time is 6 hours 47 minutes. Four non-Swedish physicians were recorded communicating with medical personnel in the course of rounds of different kinds (6) and with a team (1). Four rounds were surgery rounds, one of which was a so-called "candidate round" in which physicians who are still receiving medical training are involved. IraqD14 and GerD13 were at the end of their training session and were recorded together with other candidates in the candidate round, in which a senior Swedish physician acted as a supervisor. In addition, they were recorded in ordinary hospital rounds (2), involved in interactions with nurses. PolD17 and IraD6, an X-ray specialist and a specialist in geriatrics/rehabilitation were recorded during neuro and rehabilitation rounds, respectively. IraD6 was also recorded during a rehabilitation team meeting after her consultation with a patient. During the team meeting, the physician, the patient and the other personnel discuss the treatment process.

7.2 Results

7.2.1 Views of communication (non-Swedish physicians and Swedish medical personnel)

As mentioned in section 4.2, the novelty of the workplace, together with language problems and cultural differences, might combine to create a complicated and stressful experience for the non-Swedish physicians, who are often received with curiosity and caution by the other personnel. In their situation, it is good to be open, understanding that one has a lot to learn; one also needs to keep a low profile at the beginning, remembering that it is not beneficial to talk about one's own good qualities due to the negative attitude in Swedish society to boasting, rooted in the *Jantelagen* ('Jante law'). Consider the comment from the Norwegian physician NorD21:

Jag tror man skulle la väre med att skryta. Försiktigt och fråga om råd. Då blir man sedd positivt. Om man kommer som ny och börjar berätta hur mycket man kan, även om de är väldigt duktiga, ska det visas på efterhand.	*I think one should avoid boasting. Carefully and ask for advice. Then you are positively perceived. If you are new and start telling people how much you know, even if they are very skilled, it should show afterwards.*

The routines at Swedish health care workplaces are often different from the ones in the physicians' home countries; many workplaces have binders containing rules and guidelines, as well as websites, but it can be complicated to find them and understand them, comments the Hungarian physician HuD3:

Man måste lära riktlinjerna. Jag kommer ihåg de har sagt att det finns riktlinjer och vi har sett en stor pärm. Nej det är omöjligt att läsa, även omöjligt att läsa på svenska.	*One must learn the guidelines. I remember that they said that there are guidelines and we saw a big binder. No, it's impossible to read, even impossible to read in Swedish.*

In spite of the problems, the majority of the non-Swedish physicians and the Swedish personnel are satisfied with their communication (Q.34 and Q.13, respectively, on the questionnaires for the non-Swedish physicians and Swedish health care personnel):

Table 86: Non-Swedish physicians and Swedish health care personnel: satisfaction with communication (Q.34 and 13 respectively)

Non-Swedish physicians (Q.34)

Question	**Alternatives/number and %* of respondents per alternative**					**# of resp.**
How do you experience your com munication with Swedish colleagues?	Satis factory	Less satis fac tory	It is characteri zed by a mutual command of language and communi cation	It is charact erized by a mutual cultural under stan ding	Other	
Non-Swedish physicians	56 66%	9 11%	21 25%	16 19%	1 1%	85
Male	35 64%	5 9%	14 25%	10 18%	1 2%	55
Female	21 70%	4 13%	7 23%	6 20%	0 0%	30
*Percentages exceed 100% because the total is based on respondents and each respondent was allowed to give more than one response.						

Swedish health care personnel (Q.13)

Question	**Alternatives/number and %* of respondents per alternative**					**# of resp.**
How do you experience your com munication with non-Swedish physicians?	Satis factory	Less satis fac tory	It is characteri zed by a mutual command of language and communi cation	It is charact erized by a mutual cultural underst anding	Other	
Swedish personnel (all)	62 60%	17 16%	24 23%	16 16%	14 14%	103
female nurses	28 62%	9 20%	7 16%	11 24%	6 13%	45
male nurses	5 71%	1 14%	1 14%	1 14%	3 43%	7
female physiothe rapists	3 27%	1 9%	3 27%	2 18%	3 27%	11
female assistant nurses	17 65%	3 12%	10 38%	0 0%	0 0%	26
physicians	5 83%	1 17%	0 0%	1 17%	1 17%	6
care assistants and laboratory assistants	4 50%	2 25%	3 38%	1 13%	1 13%	8
*Percentages exceed 100% because the total is based on respondents and each respondent was allowed to give more than one response.						

The majority of the **non-Swedish physicians** are satisfied with their communication with the Swedish health care personnel. Only 11% describe it as "less satisfactory." We can also see that the non-Swedish physicians are less satisfied with their communication with their colleagues than with their communication with their Swedish patients (i.e., only 1% of the non-Swedish respondents describe their communication with the Swedish patients as "less satisfactory").

The non-Swedish physicians describe their communication as characterized by a mutual command of language and communication more (25% of respondents) than as characterized by a mutual cultural understanding (19%). This is similar to the picture of communication with the Swedish patients (i.e., the non-Swedish physicians report experiencing more satisfaction with language than with cultural understanding). However, while 41% of non-Swedish physicians consider their communication with their Swedish patients to be

characterized by a mutual command of language and communication, the same alternative received only 25% of responses concerning communication with Swedish health care personnel.

Considering **gender**, 9% of male and 13% of female non-Swedish physicians report a lack of satisfaction, which seems to indicate that the male non-Swedish physicians are somewhat more satisfied with their communication with the Swedish health care personnel than the female physicians. At the same time, somewhat more females than males chose the alternative "satisfactory" (70% vs. 64%).

Concerning the views of the **Swedish health care personnel** on this issue, though the number of respondents is not high enough to draw definite conclusions, it can be seen that the alternative "less satisfactory" was chosen by 16% of the Swedish personnel; participants in the "nurse" category (20% female and 14% male) chose this alternative more than the representatives of other groups.

To summarize, the following tendencies can be observed:

The non-Swedish physicians are less positive about their communication with Swedish health care personnel than with Swedish patients, in general, and as concerns language in particular. There are some indications that the female non-Swedish physicians are more critical of their communication with Swedish health care personnel than their male counterparts. Among the Swedish health care personnel, it is primarily the female nurses who express a lack of satisfaction with their communication with the non-Swedish physicians.

A tentative explanation of the non-Swedish physicians' less positive picture of communication with personnel compared to communication with patients might be as follows.

First, the physician meets the colleagues every day at the workplace, and though changes can occur, the majority of the colleagues are the same. Therefore, if a problem or a conflict crops up, it is present for a longer time than in a medical consultation, which is limited in time, so that any problems might therefore be less "permanent."

Second, I would also point to the influence of activity here. The physician, whether Swedish or non-Swedish, plays a leading role in consultation, as he/she has medical competence (in spite of language problems and the patients' "stronger" position as native speakers). The patient's subordinate position as a health care seeker allows the physician to feel more confident in his/her role. Even if the patient helps the physician with language and might question his/her linguistic and professional competence, this is often kept between the two of them (though it may, of course, be known to some extent by the other personnel, for example, if the patient complains). The situation is different with colleagues. The physician may be questioned, for example, by nurses, whom the non-Swedish physicians often describe as more educated than nurses in their home countries. Thus, conflict between colleagues is often more visible.

Another factor that might have an impact here is that communication with colleagues encompasses a wider variety of activities than communication with the patients. It includes, for example, communication at lunch, team meetings, rounds, administrative meetings, conferences, and so on. Therefore, it might require a higher level of language competence (a

richer vocabulary, writing skills, etc.), as well as social competence, than communication with the patients. Consequently, it can be more complicated for the non-Swedish physicians to manage.

Concerning gender and the female non-Swedish physicians' somewhat lower satisfaction than their male colleagues, a similar explanation to the one provided concerning communication with the patients may apply here: females are more sensitive to certain aspects of communication. It is also worth mentioning that gender-based segregation in the female-dominated health care system might also have an impact. Robertsson (2003), in his thesis on gender segregation in Swedish health care, claims that while male doctors consider that only competence and capability count in order to be successful in working life, female doctors believe that there is a structure in the female-dominated Swedish health care system that hinders them and their career opportunities. A female physician is seen by the larger female group of personnel as

> someone who is not satisfied with being part of the larger female group of health care personnel, but gets up to a higher level and places herself with the men and the future leadership. It also implies being an outsider.
>
> (Lichtenstein, 1998, p. 43, our translation).

Turning to the **Swedish personnel**, the female nurses are more critical than the other occupational categories (it should be noted again that some categories are represented by too few respondents). I received the same impression from the interviews and observations as well. A possible reason for the Swedish female nurses' being least satisfied with their communication with the non-Swedish physicians is that physicians and nurses are two occupational categories that often have to work together. As the nurses have the closest contact with the non-Swedish physicians and are subordinate to them, communication breakdowns because of a physician's language problems and/or cultural differences influence their work more than that of the participants in other categories. If a physician lacks language competence, the nurse has to function as an interpreter during rounds and consultations (see Examples 15 and 16), which adds extra work to the daily routines. In the following section, I discuss the physician-nurse relationship in more detail and comment on why it is the female nurses who seem to be least satisfied.

7.2.2 Physician-nurse relationship: culture, gender and power

To start with, it should be pointed out that the nurse-physician relationship can be problematic even when the linguistic and cultural backgrounds of physicians and nurses do not differ. Kramer and Schmalenberg (2003) point out that power is the dominant aspect in the physician-nurse relationship. The relationship can be more or less unequal; the authors describe five types of physician-nurse relationships: *collegial* (highest equality), *collaborative*, *student-teacher*, *neutral*, and *negative* (lowest equality, negative outcomes). The power imbalance results from role differences, based on the nurse's "care" and the physician's "cure" ideologies. The nurse spends more time with patients and often has a closer relationship with them than the physician, whose contact with patients is often much more limited. Differences in education, status and salary also exist (for a more detailed overview, see also Corser, 2000). Iacono (2000) mentions that this relationship is so significant that nurses have a tendency to "leave their hospital jobs because of less than

satisfactory relationships with physicians" and that it is "stressful by its very nature due to differences (perceived or real) in professional power and status" (p. 43).

Cultural differences have an impact on the physician-nurse relationship; the larger power distance between physician and nurse in certain cultures results in a more hierarchical relationship, little autonomy for the nurse and less influence on decision-making; it is the physician who has the responsibility. The opposite is true in the societies with a smaller power distance: the physician and nurse roles are seen as complementary, and there are more possibilities for the nurse to be involved in decision-making. For a detailed analysis and an overview of the relevant literature, see Hojat et al. (2003).

In Sweden, the health care system is less hierarchical or, to be more precise, less visibly hierarchical than in most of the countries that the non-Swedish physicians come from. In the questionnaire, the non-Swedish physicians were asked to compare the power distance between subordinates and superiors in Sweden with that in their respective home countries (Q.33). The Swedish personnel were also asked how they experienced the non-Swedish physicians' views of the differences between superior and subordinate, compared to Swedish physicians (Q14). The results are presented in Table 87:

Table 87: Non-Swedish physicians and Swedish health care personnel: difference between superior and subordinate (Q.33 and 14 respectively)

Non-Swedish physicians (Q.33)

Question	**Alternatives/number and % of respondents per alternative**			**# of resp.**
The difference between superiors and subordinates, compared to your home country, is	more hierarchical in Sweden	less hierarchical in Sweden	No difference	
Non-Swedish physicians	2 2%	67 82%	13 16%	82
Male	2 4%	48 91%	3 6%	53
Female	0 0%	19 66%	10 34%	29

Swedish health care personnel (Q.14)

Question	**Alternatives/number and % of respondents per alternative**				**# of resp.**
Non-Swedish physicians' views of the difference between superiors and subordinates is	more hierarchical than the view of Swedish physicians	less hierarchical than the view of Swedish physicians	No difference	No experience	
Swedish personnel (all)	33 32%	3 3%	50 48%	18 17%	104
female nurses	17 38%	0 0%	18 40%	10 22%	45
male nurses	2 33%	0 0%	4 67%	0 0%	6
female physiotherapists	5 42%	1 8%	4 33%	2 17%	12
female assistant nurses	2 8%	0 0%	22 84%	2 8%	26
physicians	6 100%	0 0%	0 0%	0 0%	6
care assistants and laboratory assistants	1 11%	2 22%	2 22%	4 45%	9

The majority (82%) of the **non-Swedish physicians** consider the difference between superior and subordinate to be less hierarchical in Sweden while only 16% answered that there is no difference. The respondents who report experiencing no difference come from Nordic countries and Hungary (4 respondents each), the Mediterranean region and the former Yugoslavia (3 and 2 respondents, respectively). Concerning **gender**, it is interesting that the male non-Swedish physicians report the power distance being smaller in Sweden to a greater extent than the females do (91% vs. 66%). This might indicate the males' heightened sensitivity to power and status issues, which I mentioned in Chapter 4 when discussing how the male non-Swedish physicians are more likely than their female colleagues to feel that their patients confuse professional and language competence (see also Wood and Reich, 2006).

As for the **Swedish health care personnel's views**, 32% of the respondents find that the non-Swedish physicians have a more hierarchical view of the difference between superior and subordinate than Swedish physicians, and 48% chose the answer "no difference." The nurses, physiotherapists and Swedish physicians are more likely to report finding that the non-Swedish physicians have a more hierarchical view of the relationship between superior and subordinate than the representatives of other categories.

In light of this discussion of power distance, one of the reasons why the female nurses report lower satisfaction than the respondents in other occupational categories might be that non-Swedish physicians who come from cultures with a larger power distance between superior and subordinate than the Swedish norm might find it strange and unnecessary to explain their decisions to nurses (and other people in subordinate positions); this might lead to a lack of satisfaction on the subordinates' (nurses') side. The Swedish nurse SweN1, who is responsible for a hospital unit, comments on the problems with one of the non-Swedish physicians who worked at her workplace:

Om hon [läkaren från ett östeuropeiskt land] ordinerade någonting och så kunde tjejerna [sjuksköterskorna] säga ”nä det stämmer inte” sade hon ”jo det ska vara så” Hon [läkaren] var van att arbeta på ett annat sätt.	*If she [the physician from an eastern European country] prescribed something, the girls [the nurses] could say, "no, that's not correct." She said, "why yes, it should be like this." She [the physician] was used to a different way of working.*

Although a hierarchy exists in Swedish health care, it is not very visible; for example, a physician is addressed as *Du* ('you', informal) or by his/her first name rather than "Doctor." A Swedish nurse, who often has more education than nurses in developing countries, might even question the physician and not "serve" him/her. Consider the excerpt from an interview with an Iranian physician (IraD6), which exemplifies these issues (adapted from Berbyuk et al., 2006):

Man har mindre HJÄLP av de [svenska sjuksköterskor] jämfört med sjuksköterskor i Iran. När man vill göra någonting, man måste SÄGA TILL hela tiden. Jag säger till exempel jag ska gå och undersöka patienten. I Iran hade jag alla mina undersökningsgrejer där beredda, det var sjuksköterska som hjälpte till med allting. Här måste man fråga man måste säga flera gånger ja det är inte självklart att de ska göra.	*You get less HELP from them [Swedish nurses] compared to nurses in Iran. When one wants to do something, one has to TELL them all the time. I say, for example, that I will go and examine the patient. In Iran, I had all my examination instruments there ready; it was the nurse who assisted with everything. Here one has to ask, one has to say several times. Well, it's not obvious that they should do it.*

Asking subordinates for help is also related to another feature of Swedish communicative style: indirectness. Consider the comment from a Finnish physician (FinD22) that explains this:

Om man vill ha någon sak gjort [i Sverige] går man inte till en person och säger "gör det här". Utan man gömmer det och säger att ”Du just nu kan det vara en stor hjälp för mig. Har du möjligen tid att hjälpa mig just med den här uppgiften jag sitter lite tajt med tiden". Man kan inte gå bara fram och säga kan du göra det här åt mig. Då uppfattas det negativt.	*If one wants something done [in Sweden], one doesn't walk up to a person and say "do this." But one hides it and says that "Listen, right now it would be of great help to me. Do you possibly have the time to help me with this task – I am a little pressed for time" One cannot just walk up to a person and say "can you do this for me." That would be negatively perceived.*

Another factor that might have an impact on communication between the non-Swedish physicians and female nurses is the difference in their views of gender roles. In Sweden, gender equality is emphasized. When a male non-Swedish physician (especially a dark-haired one, often referred to in the questionnaires as "a Muslim doctor," even though he might not actually be a Muslim) gives "orders" to the female nurses, as he would in his home country, the nurses may consider it as an act of "woman-oppression," in light of the Swedish focus on gender equality.

To summarize this subsection, the majority of non-Swedish physicians experience the power distance between the superior and subordinate as being smaller in Sweden. This difference in power distance, as well as a difference in views of gender roles in the non-Swedish physicians' home countries and Sweden, might have a negative impact on their communication with personnel, especially female Swedish nurses.

7.2.3 Swedish personnel as informal teachers during hospital rounds

In addition to helping the non-Swedish physicians during consultations with patients (see section 4.4.), the medical personnel also help them with other work-related activities, such as hospital rounds, team meetings, etc. In this section, I provide a few examples of this kind of help. In the example below, the physician (GerD13) and the nurse are talking during the hospital round.

Example 83. "How do you explain this?" (GerD13)

The female physician and a male nurse are sitting in the room going through the patient's file to prepare for the patient consultation. The physician explicitly says that she is not good at giving explanations and asks the nurse for help in formulating the explanation

Speaker	Transcription	Translation into English
$D:	**<1 hur >1 förklarar man detta att <2 e >2 tarmen hade åkt <3 in >3**	***<1 how >1 do you explin that <2 er >2 the intestines had slipped <3 in >3***
@ <1 head movement start: turns to N >1 @ <2 head movement start: N turns to D >2 @ <3 gaze start: eye contact >3		
$N:	< // > invagination[38] ja	*< // > invagination yeah*
@ < head movement: gentle nod >		
$D:	a: / och e e	*a: / and er er*
$N:	<1 åkt >1 in i sej <2 SJÄLV >2 elle va säge man <3 >3	*<1 slipped >1 in to it <2 SELF >2 or what would you say < 3 >3*
@ <1 head movement stop: N turns to D >1, <1 gaze stop: eye contact >1, <1 gaze: looks up to her right >1 @ <2 hand gesture: approaches both hands and moves them past each other >2 @ <3 head movement: turns to D >3, <3 gaze start: eye contact >3		
$D:	åkt in i se se själv då < >	*slipped in it self then < >*
@ < gaze stop: eye contact >, < gaze start: D looks down >		
$N:	m:	*m:*
$D:	<1 a >1 fö ja e // ja e lite så e dåli på å förklara / <2 de tro ja >2 <3 // >3 men e /a ja kan e ringa e	*<1 yes >1 because I'm er // I'm a bit like er bad at explaining / <2 I think so >2 <3 // >3 but er / well I can call er*

The nurse helps the physician to formulate her message in Swedish so she will be able to provide a clear explanation of the patient's condition to his relatives by telephone.

Personnel members are also observed explaining words the physicians do not understand, as illustrated below:

38. "An act or process of invaginating: as a) the formation of a gastrula by an infolding of part of the wall of the blastula; b) intestinal intussusception" (http://medical.merriam-webster.com/medical/invagination).

Example 84. "Fräter" (GerD13)

The female physician and the male nurse are talking during the hospital round

Speaker	Transcription	Translation into English
$D:	just de // ja: <1 e >1 (..) skulle vi e a (...) <2 /// (...) <3 / >3 **va är en <4 frätande känsla >2 <5 // >4 (...) >5**	*of course // yeah: <1 er >1 should we er eh (...) <2 // / (...) <3 / >3* ***what is a <4 corrosive feeling >4 <5 // >4 (...) >5***
@ <1 head movement stop: turns to N >1 @ <2 gaze: D reads in the case book >2 @ <3 head movement: N turns to the case book >3 @ <4 head movement: N turns to the case book >4 @ <5 head movement: turns to N >5		
$N:	att nånting < fräter >	*that something < corrodes >*
@ < gaze: eye contact >		
$D:	<1 a / de är de ja <2 inte >2 [1 fattar >1 <3 // >3]1	*<1 yeah / that's what I <2 don't >2 [1 understand >1 <3 // >3]1*
@ <1 giggling >1 @ <2 head movement: negative shake >2 @ <3 giggle >3		
$N:	[1 a de e aså att e]1 e m // om du häller <1 <2 syra [2 //]2 på nånting så >1 <3 fräte de >2 / >3 och e // förstå du va ja menar	*[1 well it means that er]1 er m // if you pour <1 <2 acid [2 //]2 on something it >1 <3 corrodes >2 / >3 and er // do you understand what I mean*
@ <1 hand gesture: holds up both hands, one above the other, palms facing each other >1 @ <2 gaze: eye contact >2 @ <3 hand gesture: moves his fingers downwards to the sides >3		
$D:	[1 a]1	*[1 yeah]1*
$D:	[2 a okej < // > ja]2	*[2 yeah okay < // > yeah]2*
@ < gaze start: D reads in the case book >		
$D:	ja // < fressend >	*yeah // < fressend >*
@ < other language: German >		
$N:	va sa du	*what did you say*
$D:	< fressend > e säge man på < tyska >	*< fressend > er it's called in German*
@ < other language: German > @ < pronunciation: tüska >		
$N:	< fressend > / de e e [att de e (...)]	*< fressend > / it means er [that it's (...)]*
@ < other language: German >		
$D:	[a / a] // varför säger (...)	*[yeah / yeah] // why does (...)*
$N:	men förstå du va ja menar	*but do you understand what I mean*
$D:	< ja >	*< yeah >*

The German physician explicitly asks the nurse for an explanation of the Swedish expression *frätande känsla* ('corrosive feeling'). Although the nurse does not immediately understand the physician's question, he attempts to explain what the word means. The German physician retrieves the German word *fressend*, the meaning of which is similar to the Swedish *frätande* ('corrosive'). It is interesting to observe that the nurse repeatedly checks to make sure the physician understands his explanation by asking f*örstå du va ja menar* ('do you understand what I mean?'). Note that, in response to the nurse's first inquiry about understanding, the physician replies with *a* ('yes'), which does not seem to satisfy the nurse, in spite of the

physician's drawing parallels with German. The nurse repeats his inquiry, and the physician answers with *ja* ('yes').

This example illustrates that feedback can be misleading; it does not necessarily signal understanding, but listening and attention, and thus the nurse remains anxious. As mentioned by Allwood and Ahlsén (1999), the functions of feedback comprise the indication of contact, perception and understanding; in the case above, only the first function of feedback is fulfilled (contact), but not necessarily the second and third. It is important to pay attention to this aspect, because a colleague (or a patient) might get an impression that the non-Swedish physician understands what he/she is telling him/her since the physician is providing positive feedback, while the physician might not understand it at all. Consequently, the patient /colleague might not consider it necessary to explain or repeat the information provided, and the information exchange in the interaction would be insufficient, which might have negative outcomes for the patient's care. Li (2006) also mentions the misleading role of feedback in intercultural encounters.

It is not uncommon for non-Swedish physicians to be unwilling to express their lack of understanding. Nodding and saying *yeah*, even though one does not understand what is being said, prevents one from losing face, but, as I have pointed out, might raise concerns about medical safety. The female physiotherapist PersPhys1 comments on this issue:

Det inverkar ju på den medicinska säkerheten om läkaren inte tillfredsställande kan delge och tillgodogöra sig information.	*Well, it influences medical safety if the physician is unable to inform and understand information satisfactorily.*

The non-Swedish physicians are not only Swedish language *learners*, but also possibly *teachers* of their native languages (consider the nurse repeating the German word *fressend*) to the personnel; in the process of learning Swedish, the physicians give the personnel insights into their native languages and cultures.

In example 84, the similarity between Swedish and German is helpful for the physician's language acquisition. In other cases, though, it can be misleading, as in the example below, in which the Swedish senior physician explains to the candidates, including GerD13 and IraqD14, the difference between certain English and Swedish terms. IraqD14 ($IraqD) suggests that the problem with the patient may be *ileus* (Eng. 'ileus'1) and the senior physician ($L) comments on this:

Example 85. "Ileus versus paralysis" (GerD13 and IraqD14)

Speaker	Transcription	Translation into English
$IraqD14:	kan de vara en e bild <1 af >1 inflammation och <2 ilius[39]>2 som	*could it be er a picture <1 of >1 inflammation and <2 ilius >2 that*
@ <1 SO: av/of >1 @ <2 SO: ileus/ileus>2		
$L:	ja: om du me ileus menar paralys	*yes if by "ileus" you mean "paralysis"*
$IraqD14:	paralys ja	*paralysis yes*

As the interaction continues, the senior physician asks the German physician whether she understands the difference, and she says that she does not. The senior physician explains:

Example 86. "Ileus versus paralysis" (GerD13 and IraqD14) (cont.)

Speaker	Transcription	Translation into English
$L:	m på engelska så betyder ilieus paralys	*m in English "ileus" means "paralysis"*
$GerD13:	jaha: okej	*I see okay*
$L:	m < > å på svenska betyde ileus passagehinder	*m < > and in Swedish "ileus" means "bowel obstruction"*
@ < clear throat >		
$GerD13:	m /	*m /*
$IraqD:	m	*m*
$L:	elle tarmvred	*or "tarmvred"*
$L:	< > [men man kan ju] också e om man säjer paralytisk ilius	*< > [but you could of course] also er if you say "paralytic ilius"*
$IraqD:	[å man kan]	*[oh you could]*
$L:	a på svenska säge man paralytisk ileus om man specifikt MENAR de som på engelska heter < ilius >	*yes in Swedish you say "paralytisk ileus" if you specifically MEAN what in English is called < ileus >*
@ < other language: English >		
$GerD13:	< okej > /	*< okay > /*
$L:	m / å på engelska heter de VI kallar ilius / <1 small bowel obstruction >1 / <2 sbo >2 <3 >3 /	*m / and in English what WE call ileus is called / <1 small bowel obstruction >1 / <2 SBO >2 <3 >3 /*
@ < head movement: GerD13 nods > @ <1 other language: English >1 @ <2 abbrevation >2, <2 other language: English >2 @ <3 head movement: GerD13 nods >3		

Staff members also help the physicians with written language. Consider the example below, in which a nurse helps a physician to spell a word:

39. Obstruction of the intestine due to paralysis. Also called paralytic ileus (http://www.medterms.com/script/main/art.asp?articlekey=3896).

Example 87. "Symptom or symtom" (GerD13)

Speaker	Transcription	Translation into English
$D:	skriver man <1 symtom >1 utan <2 p >2 / på svenska	*do you spell <1 symptom >1 without <2 p >2 / in Swedish*
@<1 pronunciation: sümtom >1 @ <2 letter >2		
$N:	a	*yeah*
$N:	elle man KAN skriva me < p > också / om man vill	*or you CAN write with < p > also / if you want*
@ < letter >		

In addition to exemplifying language learning at the workplace, the excerpts from interactions in this section illustrate how cooperation works between the non-Swedish physicians and the Swedish personnel. (I discussed the issue of cooperation between the non-Swedish physicians and their Swedish patients in section 4.4.) In their communication, the personnel and the non-Swedish physicians need to reach a shared understanding of the problem so they can help the patients. This motivates the former to provide language help and the latter to ask for it if they need it. However, similarly to the situation with the patients, the non-Swedish physicians might feel uneasy asking for help from their colleagues (especially the subordinates), as this might be treated as a sign of incompetence. Moreover – not only concerning language, but also concerning help with other things – the high work tempo means that personnel are not always able to help the physicians. The non-Swedish physicians comment that, when they ask for help, they sometimes hear *jag har inte tid att hjälpa dig* ('I don't have time to help you'), but if they make a mistake, they hear *du borde ha frågat* ('you should have asked'). Furthermore, colleagues might avoid correcting/helping the physicians with language to save the physicians' "face."

To sum up, members of the personnel are observed to help the non-Swedish physicians with language not only during consultations, but also during other work-related activities. However, the non-Swedish physicians might be unwilling to express their problems with understanding and the personnel might not have time to help, which could impair medical safety.

7.2.4 Conflict avoidance: not hurting people versus loneliness and feelings of critical observance

As I mentioned in Chapter 2, Swedes draw a sharp line between private and public life (Phillips-Martinsson, 1992; Allwood, 1999; Herlitz, 2003). Interviewing the non-Swedish physicians, I often experienced concealed but still strongly felt feelings of loneliness and exclusion, together with being "singled out" by, among other things, their accent, behavior and appearance. In addition, the Swedish conflict avoidance behavior, which manifests in the avoidance of direct confrontation even related to trivialities (e.g., language mistakes, work routines, etc.) can unfortunately create a feeling that "they talk behind my back," "they lie," or "they collect a 'file' and go to the boss and complain," in physicians who are used to more open conflict-solving strategies. *Man kanske kan få lite mer feedback hemma* ('One might receive somewhat more feedback back home'), says a Hungarian physician (HuD5) carefully. *Jag kände mig utlokaliserad* ('I felt out of place'), comments a physician from Iraq (IraqD14) and adds: *Även om man frågar, finns inte många som vill säga negativa saker* ('Even if you ask, there aren't many who are ready to tell you negative things').

Conflict avoidance and the fear of hurting and insulting people often mean that constructive criticism is not given, which can hamper a physician's professional development.

7.2.5 Successful integration in Swedish health care workplaces

Both the non-Swedish physicians and the Swedish health care personnel were asked a similar multiple-choice question about what things are important to do when meeting with Swedish colleagues ("When meeting Swedish colleagues, it is important to…," Q.39 and Q.18 in the respective questionnaires). Their responses are presented in Table 88 (also briefly presented in Berbyuk et al., 2003):

Table 88: Non-Swedish physicians and Swedish health care personnel: integration in the workplace (Q.39 and Q.18 respectively)

Question	**Alternatives/number and %* of respondents per alternative**						**# of resp.**
When meeting Swedish colleagues, it is important to:	avoid conflicts	be indirect	be neutral	not distinguish oneself	take coffee breaks together	other	
Non-Swedish physicians							
non-Swedish physicians	46 55%	13 15%	29 34%	24 28%	53 62%	4 5%	85
Male	31 56%	4 7%	27 49%	17 31%	33 60%	4 7%	55
Female	15 50%	9 30%	12 40%	7 23%	20 67%	0 0%	30
Swedish personnel							
Swedish personnel (all)	18 21%	3 3%	19 22%	13 15%	42 48%	30 34%	88
female nurses	4 11%	2 6%	5 14%	5 14%	16 46%	12 34%	35
male nurses	1 20%	0 0%	1 20%	0 0%	1 20%	4 80%	5
female physiotherapists	1 9%	0 0%	2 18%	2 18 %	3 27%	7 64 %	11
female assistant nurses	8 33%	1 4%	5 21%	6 25%	16 67%	2 8%	24
physicians	2 33%	0 0%	4 67%	0 0%	3 50%	1 17%	6
care assistants and laboratory assistants	2 29%	0 0%	2 29%	0 0%	3 43%	4 57%	7

* Percentages exceed 100% because the total is based on respondents and each respondent was allowed to give more than one response.

To start with the **non-Swedish physicians**, 62% of them chose the alternative "take coffee breaks together." About 55% find that avoiding conflict is the most important strategy for successful integration. Being neutral and not distinguishing oneself were chosen by 34% and 28% of respondents. Concerning **gender**, the female physicians consider it more important to be indirect than the male physicians (30% of the female non-Swedish physicians chose the alternative "be indirect" compared to only 7% of the males). Apart from indirectness, though the amount of data means one can draw only tentative conclusions, the male non-Swedish physicians stress conflict avoidance, being neutral and not distinguishing oneself more than

the female ones, while the female physicians emphasize taking coffee breaks together more. Other answers provided were *vara sig själv och ej spela teater* ('be yourself and don't play-act'), *ha mer kontakter* ('have more connections'), *vara korrekt och vänlig* ('be polite and friendly'), *ha tid för att lyssna* ('have time to listen'), *vara tydlig* ('be clear') etc.

For the **Swedish health care personnel**, like the non-Swedish physicians, "taking coffee breaks together" got more responses than the other alternatives (48%), especially from the assistant nurses (86%) and the female nurses (46%). The comments provided in response to the alternative "other" include *vara samarbets och laginriktad* ('be cooperative and team-oriented'), *visa respekt för varandra* ('meet each other with respect'), *inte låtsas förstå om man inte gör det* ('not pretend to understand if one doesn't'), *passa tider* ('be on time'), etc.

As can be seen, having coffee with colleagues and avoiding conflicts are mentioned by all our respondents as successful strategies for integration in a Swedish working place.

When it comes to drinking coffee, the non-Swedish physicians often report a lack of time and unwillingness to go to the cafeteria, because they do not understand what is being talked about, as PolD17 points out:

Det finns mycket att göra. Jag brukar kommer för en kort stund och tar kaffe. Jag sitter mycket mycket sällan. Jag kände inte att sitta med dem och inte förstå för att inte störa.	*There is a lot to do. I usually come for a short while and have a coffee. I very, very seldom sit down. I didn't feel like keeping them company and not understanding in order not to disturb.*

Coffee drinking is a way of getting to know one's colleagues better and goes hand in hand with conflict avoidance, which I have already mentioned a number of times since the two behaviors aim at the same goal: the familiar, pleasant, and peaceful working environment that is so highly valued by Swedes (Daun, 2005).

7.3 Summary of Chapter 7

In this chapter, I provided a brief overview and a summary of earlier published work on aspects of communication between the non-Swedish physicians and Swedish medical personnel. As with communication with patients, language problems hinder communication between the non-Swedish physicians and their colleagues. Although members of the personnel are observed functioning as informal teachers, a shortage of time makes providing language help (as well as other kinds of support) to the non-Swedish physicians an additional burden for the personnel. Furthermore, similarly to the situation with physician-patient communication, the non-Swedish physicians may be reluctant to explicitly show a lack of understanding and ask for help, while the Swedish personnel might not correct the non-Swedish physicians' language in order not to appear to be encroaching on their personal space.

Concerning cultural aspects, awareness of the *Jante law*, Swedish indirectness and conflict avoidance, relatively short power distance and gender equality are important for the non-Swedish physicians. Power distance and gender are especially visible in the physician-nurse relationship. It should be pointed out here that this relationship is not unproblematic even if the participants' cultural backgrounds are the same. However, a male physician who is used to a larger power distance and giving "orders" to subordinates might be seen by a Swedish female nurse as an "oppressor of females." The participants emphasize avoiding conflicts and being social at the workplace as successful strategies for integration into the Swedish health care workplace.

Chapter 8: Discussion, conclusions, and implications for teaching and training

The chapter reviews the main findings of the thesis. I will also discuss the limitations on the studies presented and present ideas for further research. The chapter concludes with implications for teaching and training.

This thesis is an intercultural communication study of communication between non-Swedish physicians and their Swedish patients and colleagues in the Swedish health care system. Though physician-patient communication (intercultural or monocultural) is a popular research area, the vast majority of studies have focused on situations where the patient is a foreigner and the physician is a native speaker. Similarly, relatively few studies on communication between medical personnel focus on cases where the physician is a foreigner. In addition to the studies mentioned in section 2.6.2, Andrews and Boyle (2003) briefly discuss the impact of cultural diversity on communication in health care, focusing on nurses, who, although discussed, are not the main focus of my own studies. This work is probably the first linguistic study in the area of intercultural communication research with a focus on communication between foreign physicians and native patients/personnel.

The methodology used in the thesis is another feature that sets it apart from the studies presented in Chapter 2 (Background), most of which are based on data obtained by using one or two data collection methods. As shown in Chapter 3, following Allwood's Activity Based Communication Analysis (ACA), I have combined four data collection methods – interviews, recordings of medical consultations, questionnaires and observations – in my analysis. The data obtained in these ways made it possible to determine the views on communication held by the non-Swedish physicians, Swedish patients and Swedish medical personnel and to see what communication looks like in actual interactions (i.e., intercultural and Swedish medical consultations and work meetings). Using both qualitative and quantitative methods for data analysis enabled me to get a more complete picture of communication than if I had used a single method. In addition, this thesis is based to a large extent on the analysis of recordings, which distinguishes it from studies done in Hofstede's tradition, which focus primarily on the analysis of attitudes and values. The quantitative corpus analysis of data presented in this thesis is new in intercultural communication research. It is also worth mentioning here that, when analyzing the data, I was open to other methodologies (e.g., CA analysis was used for the analysis of questions) and I often referred to the results of the research outside the linguistic field, such as medicine, anthropology and sociology.

Below, I will try to summarize and discuss my main findings, showing how they answer the specific questions posed by this thesis (which focuses on physician-patient communication) and how they relate to earlier research. Furthermore, as well as summarizing the findings that concern physician-patient communication, I will also mention issues related to communication between the non-Swedish physicians and Swedish health care personnel to present a more complete picture of communication in the health care field.

8.1 Intercultural communication in the Swedish health care system: communication between non-Swedish physicians and Swedish patients and colleagues

The aim of this thesis was to describe and analyze the intercultural communication between non-Swedish physicians and their Swedish patients and answer a number of specific research questions, listed in Chapter 1. To make it easier for the reader to follow, the specific questions are presented again here:

- **Question 1.** *What does the communication between non-Swedish physicians and Swedish patients look like? Does it differ from the Swedish way of communication? And if so how? What kinds of phenomena and difficulties are encountered by non-Swedish physicians and their Swedish patients in communication? What linguistic difficulties occur? How do they influence the interaction?*

- **Question 2.** *What are the positive effects of cultural differences and foreign language use in the process of communication? Do the participants' different approaches or ways in formulating their message sometimes lead to clarifications that are useful for both parties?*

- **Question 3.** *How are the communicative strategies the physicians use related to the parties' cultural backgrounds, i.e., what culture-specific strategies do the non-Swedish physicians who were chosen for the study use communicating with Swedish patients and how are these strategies related to the physicians' cultural backgrounds? In what ways are they different and/or similar to the typical Swedish communicative strategies in health care environment? Are there communicative strategies that are common for non-Swedish physicians independent of their cultural backgrounds?*

- **Question 4.** *The aspect of power relationships in communication: In what way is the interaction between non-Swedish physicians and Swedish patients influenced when the physician's normally dominant position as a professional participant is combined with the disadvantage of being a ¨newcomer¨ in the language and culture of the patient? To what extent does the authority given by the role of the professional person in the communicative activity compensate for a lower level of communicative and cultural competence?*

- **Question 5.** *In what sense is gender a relevant issue in the context of intercultural encounters in the medical environment? Are there certain gender-related strategies that the male/female foreign physicians use in communication with their Swedish patients?*

- **Question 6.** *Do Swedish patients contribute to the language acquisition of non-Swedish physicians? In what way do they function as "informal teachers"? How does this affect the communication – does it, for example have an impact on the distribution of power within the interaction?*

To start with, in the interviews and questionnaires, the majority of the non-Swedish physicians reported being satisfied with their communication with Swedish patients; in their turn, most Swedish patients were also satisfied with their communication with the non-Swedish physicians in general, and with regard to the expectations they had had and the amount of explanations provided in particular (section 4.2.2). Similarly, the majority of the

non-Swedish physicians and Swedish personnel, though a somewhat lower proportion, reported being satisfied with their communication (section 7.2.1).

One might naturally wonder to what extent the participants' answers are influenced by their wish to present a positive picture of integration and not to report failure (non-Swedish physicians) and their fear of being seen as racists who are prejudiced against foreigners (Swedish respondents). Respondents' honesty is often a thorny problem in studies based on the questionnaires and interviews. However, traits such as honesty and being critical of authority, which are sometimes claimed to be part of Swedish culture, might contribute positively to the sincerity of the responses obtained from the Swedish patients and personnel.

Let us start with a general overview of the similarities and differences between intercultural and Swedish medical consultations **(question [Q. 1)**.

8.1.1 Question 1

What does the communication between non-Swedish physicians and Swedish patients look like? Does it differ from the Swedish way of communication? And if so how? What kinds of phenomena and difficulties are encountered by non-Swedish physicians and their Swedish patients in communication? What linguistic difficulties occur? How do they influence the interaction?

The **similarities** in communication in inter- and monocultural consultations are primarily due to the influence of activity parameters pertaining to medical consultation. The purpose of medical consultation as a social activity is the same for both the non-Swedish and the Swedish physicians, namely to help their patients with health problems and reach a shared understanding of the problem(s) the patients have. (I have presented a general analysis of medical consultation as a social activity in section 4.1.1.)

To do this, the physicians have to obtain certain information from the patients, which they do by asking questions (***information seeking***). A comparative analysis of the questioning behavior of the non-Swedish and Swedish physicians (section 5.1) shows more similarities than differences. Both the Swedish and non-Swedish physicians use similar question types (both single unit questioning turns [SUQT] and multi-unit questioning turns [MUQT]). Among SUQT, yes/no questions are the most common question type for both groups of physicians, which is in line with previous research (Lindholm, 2003). I did not find any statistically significant differences in the frequencies of use of yes/no, declarative and fill-in-the-blank questions. No statistically significant differences were found in the number of MUQT used by the non-Swedish and Swedish physicians either. As for the patients, framing questions are the most common MUQT type they use, which is also in agreement with earlier research.

Both Swedish and non-Swedish physicians attempt to ensure understanding in the interaction (***information acknowledgment and checking***). Both groups of physicians use a lot of feedback in general (feedback words constitute one of the most common parts of speech used in medical consultation, section 6.4) and repetitions/reformulations of their patients' utterances in particular (section 5.3).

The vocabulary used in intercultural and Swedish medical consultations is also similar from many perspectives. For example, the participants' need to evaluate the patient's state of health requires the use of the adjectives *bra* ('good') and *dålig(t)* ('bad', 'poor'), and those

that describe the location of symptoms (*höger* ['right']) (section 6.5.1), The adjective *normal* ('normal') is more common in the speech of the physicians than the patients in both corpora, reflecting the differences in their roles and competencies (i.e., it is generally up to the physician as a professional to assess something as being "normal"). The majority of adverbs are also similar in both inter- and monocultural consultations (section 6.5.2). The need to talk about the time of onset of, for example, a symptom, explains the frequent use of *nu* ('now'), while indicating the location of symptoms requires, among other things, the adverb *här* ('here'). The majority of conjunctions and prepositions used are also similar for the non-Swedish and Swedish physicians (6.5.3 and 6.5.9). The participants' need to address the interlocutor and refer to themselves requires the personal pronouns *du* ('you') and *jag* ('I'/ 'me') (section 6.5.10), and discussion of a surgical procedure triggers the vocabulary related to the surgery (e.g. *mage* ['stomach'], *tarm* ['intestine'], *operation* ['surgery']), in both intercultural and monocultural medical encounters (section 6.5.6). The majority of feedback words, numerals and verbs are also similar in the intercultural and Swedish medical consultations (sections 6.5.4, 6.5.7 and 6.5.11), as are such commonly used interjections as *hej* ('hello', 'hi') and *tack* ('thank you') (section 6.5.5).

Though I did not discuss this in the thesis, the recordings of consultations show that if a physical examination is necessary, the non-Swedish physicians perform one. Some research has discussed the challenges experienced by foreign physicians in performing physical examinations (e.g., Fiscella et al., 1997), but I saw no signs of this in my data. This might stem from the fact that many of the physicians in my study come from European countries (e.g. Germany and Hungary), while the physicians from outside Europe have spent a relatively long time working in Sweden.

In addition, the Swedish patients and the non-Swedish physicians hold quite similar views of the physician's task in a medical consultation (section 4.2.1). Taking the patient's problems seriously, showing genuine interest, and inspiring trust and confidence are valued by both groups. However, even when views of the tasks are similar, it is possible (though not necessary) that participants could have different views on how to fulfill them and what they actually involve.

Now, let us turn to the **differences** between intercultural and monocultural consultations. To begin with, unlike in monocultural consultations, in intercultural consultations the physician and patient communicate across linguistic and cultural borders; consequently, it is not uncommon for language problems and cultural differences to occur and influence the interaction, as a number of studies have pointed out, including those presented in section 2.1.2). While language problems tend to be fairly "visible" causes of communication failure, cultural differences, on the contrary, are subtle and often not easily recognizable, but nevertheless have an impact on communication. This is reflected in the participants being more satisfied with language than cultural understanding in intercultural encounters, probably because they have better control over and knowledge of language than culture (section 4.2.2).

Concerning the various phenomena and difficulties that are encountered by the non-Swedish physicians and their Swedish patients in communication and their influence on the interaction, the analysis of recorded interactions and the participants' comments from the interviews and questionnaires show that it is often, though not only, language problems that have a negative impact on communication (section 4.3). The non-Swedish physicians claim that problems finding the right word are the primary language problems that have a negative

impact on their communication with their patients. We have analyzed word-finding problems in a joint article (Allwood and Berbyuk, 2006); the results are also briefly presented in section 4.3.4. In that article, we classified and illustrated the kinds of word-finding problems experienced by the non-Swedish physicians in communication with their Swedish patients (and to some extent their colleagues) and how these problems are solved. The results show that in medical consultations the non-Swedish physicians generally attempt to solve their problems by themselves, using gestures to supplement and substitute for verbal messages and taking extra time to retrieve the words they need using both vocal and gestural OCM (own communication management). Although, in the majority of cases represented in the data, the retrieval is successful (i.e., the physicians find the words they need), in other cases they have to substitute a more general word or a related word, use a medical term or simply leave the desired word out. In a few cases, the physicians even use words from their native languages or English to solve vocabulary problems, hoping that the patients will understand them. Problems with verbal code result in the non-Swedish physicians' using bodily communication to support, complement or even substitute for their verbal messages. In addition, it is possible that when they lack words to show, for example, verbal support and empathy, the non-Swedish physicians might attempt to show this non-verbally. However, though certainly appreciated by some patients, others might see it as strange and inappropriate behavior, as relatively little body contact is common in this context in Sweden. I think this would be an interesting aspect to study in medical consultation (i.e., how physicians show support and empathy to their patients across linguistic and cultural borders).

Problems with understanding also appear to be related primarily to language problems (section 4.3.3). Lacking a Swedish word and using a Latin medical term instead might make things difficult for the patients to understand, though Swedish patients are often described by the non-Swedish physicians (especially by the physicians from developing countries) as well-educated (section 4.3.1). Imperfect knowledge of colloquial language, problems with grammar and problems related to pronunciation and possibly patients' hearing problems are other primary causes of lack of understanding and misunderstanding in intercultural consultations.

Thus, for the non-Swedish physicians, good language competence is the key to successful communication with both health care personnel and patients, and consequently to a positive working experience. Having an adequate knowledge of vocabulary and grammar, and speaking slowly and clearly, especially when interacting with elderly patients with hearing problems, are essential. However, this thesis also shows that in many cases (though not always) it is practically impossible to relate the problem occurring in interaction to a single factor, such as only language or only culture, as the two are so intertwined. In addition, the physician's and the patient's gender, other background characteristics (e.g., the patient's age and education) and differences between consultation types are among the factors influencing communication.

The non-Swedish physicians' brevity in talking to their patients is a result of both linguistic and cultural factors (section 4.3.1). On one hand, the non-Swedish physicians might experience, and in fact are observed experiencing, problems formulating syntactically complex sentences. More pauses (section 6.3); more use of phrases as questions (often taken from patients' medical files; sections 5.1.3.5 and 5.1.5.1); somewhat shorter utterances, as reflected in MLU values (section 6.2); a higher proportion of OCM; and a lower proportion

of conjunctions and prepositions in the speech of the non-Swedish physicians compared to the Swedish physicians (section 6.4) all indicate their problems. Being brief might result in being direct and consequently being perceived as harsh and unethical by Swedes, who are used to a more indirect communicative style. In addition, cultural influence should not be underestimated here (e.g., preference for a more direct communication style in Germany than in Sweden, illustrated by Example 1 "You don't need care," section 4.3.1). On the other hand, physicians who are used to a larger power distance and a more paternalistic relationship type than is adopted in Sweden (where the mutuality type of relationship predominates) might not consider it very important to explain and motivate their choice of treatment to the patients. More specifically, in a paternalistic relationship, it is often the physician who decides upon the choice of treatment and is responsible for the interaction, while the patient's voice is largely absent. As my examples throughout the thesis reveal and as Herlitz (2003) points out, the relationship between a Swedish physician and a Swedish patient is often based on mutuality, due to the relatively short power distance in Sweden (Hofstede, 2001; Hampden-Turner and Trompenaars, 1993). The patient is encouraged to play an active role in his/her own treatment process (see for example, Example 2 "It is you who decide"). The physician is an advisor, who makes recommendations, and it is often the patient who decides whether to follow the proposed treatment or not (one should not over-generalize this claim, though, as variations do exist). That is why a physician is probably more motivated to provide a detailed explanation to a patient in the latter case than in the former. This is also discussed in the study by Richter et al. (2002); an illustration is Example 4 "Fibrillations," presented in this thesis. Another factor may also be relevant, though I have not investigated it here, namely to whom physicians consider information in general and bad news in particular should be delivered. As I mention in the background chapter of the thesis (section 2.6.1), in collectivistic societies the patient's family has a bigger role than in individualistic societies. In countries with more collectivistic cultures such as Russia and Iran it is often (though not always) the patient's family to whom the physician delivers information; in the more individualistic (from this perspective, at least) country of Sweden it is customary to give the information to the patient. This issue should be investigated further and should undoubtedly be taken into account in educational programs (see also, for example, Hall et al., 2004).

The need to justify one's decisions to subordinates (e.g., nurses) might be a new and a challenging experience for non-Swedish physicians in communication with personnel (section 7.2.2). The non-Swedish physicians who come from cultures with larger power distances might not consider it necessary to explain their decisions to the nurses, which is not appreciated by the latter, as they have more frequent and closer contact with the patients, who often ask them what the physicians say (especially in case of language problems, when the patients may use the nurses as "interpreters"). Not getting a good explanation from the physician means that the nurse is not able to provide a good explanation to the patient. (The nurse is sometimes informally called the "patient's attorney" [Swedish patientens advokat].)[40]. Furthermore, a nurse who has worked in the Swedish health care system for many years (some of the nurses who participated in the study had about 40 years of work experience in Sweden), who knows the routines (which can be complicated for a new

40. It is worth mentioning here that there is a rather extensive body of research on the issue of "advocacy in nursing" which focuses on the nurse's role in representing the patient's interests (e.g., Mallik, 1997).

physician to learn at the beginning, see sections 4.3. and 7.2.1) and is used to a less hierarchical physician-nurse relationship might require explanations and even question the physician's decisions. (this In Swedish, this is often phrased something like *Så gör vi inte här* ['We don't do it like that here'].) Such a situation can result in a conflict, as physician may see the nurse's behavior as signaling a lack of respect and questioning his/her professional competence. The impression may be strengthened by the use of an informal communication style and *du* ('you') instead of titles. (Reverting to the subject of physician-patient communication, although the Swedish patients report valuing it when their physicians address them by their first name [section 4.2.1], which reflects their preference for relative informality in interactions, the patients of the non-Swedish physicians are less likely to address them with du than the patients of the Swedish physicians, which might indicate a more formal attitude toward non-native speakers.)

Moreover, in Hofstede's terms, in "feminine" Sweden, a female nurse used to gender equality might see a male physician as an "oppressor of women," who does not take her point of view into account.

Here, it might be worth discussing the Swedish expression *Så här gör vi här i Sverige* ('In Sweden we do it like this') and Hofstede's view of Sweden as a country with low uncertainty avoidance. As pointed out by Smith et al. (2003, p. 499-500), the Swedes exhibit "higher reliance on rules as well as on beliefs that are widespread in my nation [Sweden] as to what is right," which are not dependent on legislation, than other Nordic managers, such as the Finns, Danes, Norwegians and Icelanders. This description and the fact that Lewis (2000) and Hall (1984) place Sweden among the linear-active/low context countries, respectively, in which doing one thing at a time, following a timetable, etc., can be seen as signs of how Swedes strictly follow the rules (written or unwritten), tend to contradict Hofstede's analysis. It should be pointed out that new "non-Swedish" ideas might be (and often are) not as easily accepted in the workplace as one might presume on the basis of Hofstede's claims about the Swedish openness to innovations and "low" uncertainty avoidance.

Language problems and cultural competence also affect how the physicians initiate and follow an informal conversation in interactions, exemplified by Example 7 "Bend plastic." Lack of vocabulary, and more specifically, lack of knowledge of words outside the medical field, together with lack of familiarity with Swedish culture and society, mean that the non-Swedish physicians experience problems talking about issues that are not related (or not directly related) to their patients' health problems. This is unfortunate, as small talk is important for relationship building (e.g., it is often beneficial to give the patient "a break" from sometimes psychologically difficult talk). An ability to talk about issues outside the medical field is also important for conversations with personnel (e.g., during coffee breaks), and participation in such informal activities is reported to be one of the best ways to successfully integrate into the Swedish health care culture (section 7.2.6). Thus, though the non-Swedish physicians' ability to talk about medical matters is undeniably important, a basic knowledge of Swedish culture and society as well as of vocabulary outside the medical field are important issues for training programs to cover.

Another factor that influences communication between the non-Swedish physicians and their Swedish patients and colleagues is Swedish conflict avoidance. The well-known Swedish balance between individualism and social concern, together with the relatively short power distance mentioned in earlier research (Hampden-Turner and Trompenaars, 1993; Daun,

1996), are supported by the findings of this thesis. The non-Swedish physicians report experiencing loneliness and feelings of being watched critically (section 7.2.4) and never knowing what their patients think about them (section 4.3.2). In Sweden, one is expected to 'do right for yourself' (*att göra rätt för dig*), that is, play one's role in the way that is expected and right. Hard work and being *duktig* ('clever, good') are valued, but at the same time sticking out too much is not positive, rooted in the Swedish concept of *lagom* ('just right') and the *Jante law* (section 7.2.1). Being a foreign physician attracts attention; you cannot help "sticking out" because of your accent, appearance, behavior, etc. In attempting to do their best and to show that they are good professionals, the foreign physicians may talk about their positive qualities, which can be seen as boasting and breaking the Jante law. Furthermore, as mentioned above, being indirect can be complicated for the non-Swedish physicians due to their language problems and their lack of awareness of the importance of this behavior; their directness can be seen as inappropriate behavior by the Swedes.

Swedish avoidance of confrontation, which is mentioned in a number of studies (Daun, 1996; Allwood, 1999; Herlitz, 2003), is reflected in such behaviors as not talking loudly, not quarreling openly at the workplace, adopting an indirect communicative style, etc. Trompenaars and Hampden-Turner (2002) see Sweden as belonging to a neutral culture, that is, one in which public expressions of emotion are controlled. My work shows that, though this strategy is often well-meant, avoidance of confrontation on the part of the Swedish patients and health care staff prevents the non-Swedish physicians from benefiting from constructive feedback/criticism, which is something every new physician needs in order to improve. Not knowing what the patients and personnel think about them often creates anxiety, feelings of isolation and a sense that "they are talking behind my back" in representatives of cultures in which a more open communication style and conflict handling are accepted.

Swedish physicians' indirect communicative style and less intrusive way of ***giving information*** in general, and giving advice to their patients in particular, is reflected in their frequent use of the impersonal pronoun *man* ('one') when talking about the patient and the personnel (including or excluding themselves) (section 5.2). The non-Swedish physicians tend to use this pronoun less, which might be an indication of their being more direct and concrete in their interaction with patients than the Swedish physicians (Examples 50 and 51) but may also be accounted for by the language competence factor (i.e., knowledge of how this pronoun is used).

We shall now turn to the positive effects of cultural differences and foreign language use in medical consultations **(Q. 2)**.

8.1.2 Question 2

What are the positive effects of cultural differences and foreign language use in the process of communication? Do the participants' different approaches or ways in formulating their message sometimes lead to clarifications that are useful for both parties?

Understanding is essential in medical consultation in general, and particularly when the physician and patient have different linguistic and cultural backgrounds. The non-Swedish physicians are aware that lack of language competence might cause conversational breakdowns, and so they attempt to be very clear when talking to their patients. From the analysis of recordings, this is seen in, for example, the use of multi-unit questioning turns, in which the component questions paraphrase or specify each other, which are used more often by non-native than native physicians. This phenomenon shows the non-native speakers making attempts to be clearer when they ask questions (section 5.1), and may account for one of the most common comments about the positive aspects of intercultural communication mentioned by the Swedish patients and personnel: the non-Swedish physicians are thorough; they listen, care and take time with their patients (section 4.6). In addition, the non-Swedish physicians give more intensive feedback compared to the Swedish physicians in general (section 6.4), and in the form of repetitions and reformulations in particular (***information acknowledgment and checking***, section 5.3). This is in line with previous research on the use of this type of feedback by non-native speakers (Allwood, 1993a; Svennevig, 2004). At the same time, as I have discussed (section 7.2.3), feedback can be misleading. By saying ja, a speaker does not always mean "I understand" but rather "I'm listening, I hear what you say," signaling contact, but not necessarily perception and understanding (Allwood and Ahlsén, 1999). Attention must be paid to this aspect in intercultural encounters in general, and medical encounters in particular, as it can negatively influence information exchange and, consequently, undermine medical safety.

In the questionnaires and the interviews, the patients and personnel made a number of other comments concerning the positive aspects of intercultural medical consultations. The fact that the non-Swedish physicians may take longer to talk to patients due because of their language problems and slower tempo of interaction (see above) might result in the patients' experiencing them as taking more time and "not being in a hurry." Consultation time is often limited, and when the non-Swedish physicians take extra time due to language problems, their patients may feel that they are getting extra attention. Though it is tempting to see a link with the views of time mentioned by Hall and Lewis (i.e., maybe the non-Swedish physicians, some of whom come from polychronic/multi-active cultures have less "strict" control over consultation length than the monochronic/linear-active Swedes), I cannot say that I found any indications of this in my data.

Professional competence and being caring are also traits the Swedish patients appreciate in the non-Swedish physicians (and in Swedish physicians). Here, it is worth mentioning that a more paternalistic style, probably more characteristic of the non-Swedish than the Swedish physicians, might highlight their professional position in the consultation and this can be seen as positive by patients who prefer a paternalistic relationship with physicians (often older patients, but not necessarily). The same is true of directness, which some patients report to be a positive feature of the non-Swedish physicians' communicative style. Some patients prefer to get direct and clear directions from their physician (something along the lines of "Don't do

it" instead of "One should not do it"). This illustrates the crucial role personality factors play.

The fact that the non-Swedish physicians are attempting to do their best – as one of the patients commented, "maybe being conscious of being 'compared' to the Swedish physicians" – is noticed and appreciated by the patients, who observe them struggling with language and doing their utmost to provide medical care. The patients of the non-Swedish physicians also try to speak more slowly, which can be seen in the number of pauses (section 6.3).

8.1.3 Question 3

How are the communicative strategies the physicians use related to the parties' cultural backgrounds, i.e., what culture-specific strategies do the non-Swedish physicians who were chosen for the study use communicating with Swedish patients and how are these strategies related to the physicians' cultural backgrounds? In what ways are they different and/or similar to the typical Swedish communicative strategies in health care environment? Are there communicative strategies that are common for non-Swedish physicians independent of their cultural backgrounds?

Although the total number of non-Swedish respondents is high, the number of cultures is also high, so I can draw only tentative conclusions about their cultural background. I have already mentioned the differences in how direct the physicians are in interaction, which may be related to cultural background (e.g., German versus Swedish). Understatement and overstatement communication styles are reflected in how the non-Swedish physicians answered the questionnaire; for example, the physicians from Northern Europe are moderate in their evaluation of communication, which might reflect their being representatives of "understatement cultures." The non-Swedish physicians in general use more positive-valence adjectives, and more adjectives and adverbs with the prefix *jätte-* ('very') in particular (sections 6.5.1 and 6.5.2), which may stem from the fact that some of them are representatives of "overstatement cultures." One might also relate this feature to Gudykunst and Ting-Toomey's (1988) theory that there are four verbal communication style parameters: direct-indirect, elaborate-succinct, personal-contextual, and instrumental-affective. The data also contain examples in which some of the non-Swedish physicians (Russian and German) demonstrate greater emotionality, which might also be related to their cultural backgrounds (section 6.5.5.). The non-Swedish physicians and their patients also have different views of eye contact (section 4.2.1). Furthermore, in a number of cases, transfer from the physicians' native languages can be observed (e.g., use of feedback words, section 6.5.4; questions with particles, section 5.2.3.6, etc.).

In addition, differences between the physicians recruited from the EU/EEA countries and the physicians from outside the EU/EEA area can be observed. The latter emphasize the importance of demonstrating professional competence to their patients more than the former. Unlike the "invited" recruited physicians, physicians from outside the EU/EEA often experience more obstacles to working as physicians in Sweden, as their medical licenses are not automatically accepted, unlike the licenses of the European physicians. (Only in the last 5 to 8 years have there been programs like the "Foreign Doctors" project that support non-European personnel.) As a result, they may feel more need to prove their professional competence to the patients and colleagues.

The time spent in Sweden and the level of language acquisition are also factors that have

been observed to influence communication and should not be underestimated. Some words and constructions are less commonly used by the non-Swedish than Swedish physicians due to their complexity (e.g., *ju* ['as you know']); on the other hand, some are more common because they are borrowed from English or other languages (e.g., *okej* ['okay']). In addition, I have observed some signs that the physicians with lower language competence attempt to use certain compensatory strategies. The Hungarian physicians, who have spent the least time in Sweden and are least satisfied with their communication with patients in terms of language, use more MUQTs and more repetitions and reformulations of their patients' utterances for feedback purposes than the Iranian and Mixed group physicians; this might result from their need to be as clear as possible and to check their patients' understanding (sections 5.1.5 and 5.3.4).

A few of the examples presented in the thesis concern taboo topics in medical consultations. The non-Swedish physicians and the Swedish personnel report alcohol consumption to be a taboo-topic, and indeed it does appear to be a sensitive topic in medical consultations in Sweden (section 4.3.5).

Let us now turn to the issue of power relationships in medical consultation, which are the main focus of this thesis (**Q. 4.** and **Q. 6,** which are interrelated).

8.1.4 Questions 4 and 6

Question 4. *The aspect of power relationships in communication: In what way is the interaction between non-Swedish physicians and Swedish patients influenced when the physician's normally dominant position as a professional participant is combined with the disadvantage of being a ¨newcomer¨ in the language and culture of the patient? To what extent does the authority given by the role of the professional person in the communicative activity compensate for a lower level of communicative and cultural competence?*

Question 6. *Do Swedish patients contribute to the language acquisition of non-Swedish physicians? In what way do they function as "informal teachers"? How does this affect the communication – does it, for example have an impact on the distribution of power within the interaction?*

I have already mentioned that many of the non-Swedish physicians may have a more paternalistic relationship with their patients than Swedish physicians tend to do. In health care communication research, there is a lot of discussion of "empowering" the patient and giving the patient a chance to be involved in interaction and decision-making. This study shows that the physician is the dominant figure in a consultation, and remains so even if he/she is a foreigner and "weaker" because of being a non-native speaker and the patient is "stronger" because of being a native speaker.

Only about 3% of the utterances by the patients of both the Swedish and non-Swedish physicians are questions (section 5.1.5.1), which indicates that patients' questioning behavior probably does not depend on whether the physician is a native or non-native speaker. Furthermore, both Swedish and non-Swedish physicians speak more than their respective patients (i.e., quantitative dominance in Linell and Luckmann's, 1991, terms).

The non-Swedish physicians report being helped with language problems and the Swedish patients report helping them. However, in medical consultations, few occurrences of such help are observed in the recorded data; relatively few patients report doing this and only in a

few cases do the non-Swedish physicians explicitly ask their patients for help. The physicians' not asking for help might be explained by their unwillingness to "highlight" their lack of language competence (which patients may associate with a lack of medical competence, see section 4.5). Meanwhile, patients' hesitation about helping with language may be a face-saving strategy. Thus, I did not observe the patients becoming more "powerful" participants in intercultural medical consultations with the non-native physicians.

I have also shown how Swedish personnel members function as informal teachers in section 7.2.3.

Another important issue discussed in the thesis is gender **(Q. 5).**

8.1.5 Question 5

In what sense is gender a relevant issue in the context of intercultural encounters in the medical environment? Are there certain gender-related strategies that the male/female foreign physicians use in communication with their Swedish patients?

I have repeatedly emphasized that the amount of data the study uses cannot be considered as large enough to draw definite conclusions. However, certain interesting tendencies are worth mentioning and should receive attention in future research.

The study shows that female non-Swedish physicians, female Swedish patients and female Swedish nurses are more critical of communication than male respondents (sections 4.2.2 and 7.2.1). The female non-Swedish physicians experience more differences in their communication with their Swedish patients compared to patients in their home countries than their male counterparts (section 4.2.3). They also report getting less help from patients and are more likely than the males to change their communicative styles to match the style adopted in the host culture (Swedish health care). Likewise, the female Swedish patients are less satisfied than male patients with their communication with the non-Swedish physicians.

Female participants' critical attitude can tentatively be explained by their higher demands for relationship development and affective communication, which requires more advanced linguistic and cultural competence and might be difficult to achieve in intercultural medical encounters. Furthermore, I see a tendency on the part of the female patients to be less satisfied with communication with female non-Swedish physicians than with male ones. While the fact that female patients are more critical than male patients has been documented in previous studies (Elderkin-Thompson and Waitzkin, 1999), the female patients' lower satisfaction with female than with male physicians is not completely consistent with earlier research. For example the study by Kerssens et al. (1997) shows (though implicitly) that the female physician–female patient gender combination is more beneficial for female patients' satisfaction with communication than the male physician–female patient combination. Female patients (though, again, one should not over-generalize) often prefer female physicians as they are considered to talk more about psychological issues, express more personal interest, and converse more easily than male physicians. However, if a female non-Swedish physician fails to meet her female patients' expectations, they might be more disappointed than if the physician was male, which is probably the case in the intercultural medical consultations described here. However, it is important to understand that patients' lack of satisfaction with or preference for physicians of one gender or the other might also

depend upon a number of factors including kind of consultation (it would not be surprising to find that female patients prefer a female gynecologist; see also Kerssens et al., 1997); the physician's and the patient's personal characteristics; the nature of the problem, etc.

Let us turn now to the male participants. As mentioned above, males as a group appear to be more satisfied than the female participants. However, the male non-Swedish physicians are somewhat more concerned about the patients confusing their linguistic and professional competence, which might reflect the greater value that males generally place on status compared to females (section 4.5). Moreover, the male non-Swedish physicians and Swedish patients report being focused more on solving problems than the females (section 4.2.1), which is in line with previous research (Wood and Reich, 2006).

Here, one can speculate on the relationship between gender, language competence and intercultural communication in medical consultation. Meetings across linguistic and cultural borders often imply distance between the interactants. As I have mentioned a number of times, in medical consultation, a good physician-patient relationship is essential for the quality of health care. Irrespective of gender, the non-Swedish physicians report that they appreciate creating a personal relationship with their patients, which may be a result of their feeling a need to make contact with patients from the host culture. However, it is possible that females, in line with the previous research, attempt to build more personal relationships than males do, which might be difficult. On the other hand, males might be more focused on solving the problem and collecting more medical information, for which even a basic level of language competence might be sufficient, and this leads to their experiencing greater satisfaction with communication than the females.

The analysis of the recorded medical consultations shows that there are similarities between non-Swedish and Swedish male and female physicians, which may be related to gender. The female non-Swedish and Swedish physicians' behavior is similar in many respects, for example, asking their patients questions with the particle *eller* ('or'), which allows for an alternative answer and may be a sign of consensus-seeking behavior (section 5.1). The more intensive use of repetitions and reformulations for feedback in female-female rather than in other gender combinations might also be a sign of more patient-centered behavior (section 5.3).

The impact of such factors as **age** and **education** was not the focus of this study at the outset. However, although highly tentative, the results show that these factors should be taken into account. Lower education level and higher age on the part of patients appear to be related to more satisfaction and less criticism of the physician. Better-educated patients experience being on the same level as their physicians more than less educated patients do (which is reflected, for example, in the better-educated patients' providing more language help to the physicians, section 4.4.), and older Swedish patients are probably used to a more "paternalistic" physician than the younger generation.

There may be another reason why the older patients report being more satisfied than the younger ones. I have not found explicit evidence for this in my data, but it is possible that the non-Swedish physicians from cultures in which age is respected might show marked respect to their older patients, and thus the latter would be very satisfied with their communication.

In the thesis, I have also commented on ways to integrate successfully into the Swedish health care workplace, such as joining in the tradition of coffee breaks, being neutral and

avoiding conflicts. Overall, it is important to maintain a good working environment (in Swedish *arbetsmiljö*), which, as Hofstede (2001) pointed out, is a trait of feminine countries, of which Sweden is a prime example. It is also crucial to follow the rules of the Jante law, namely don't think you're anyone special or that you're better than us (or at least don't say so, although you can express your quality in your actions).

8.2 Limitations on the studies and avenues for further research

A number of limitations need to be acknowledged and addressed regarding the present study. They are discussed below, together with ideas for further research.

More research on non-verbal intercultural communication in health care context

As I have mentioned a number of times, I only analyzed the use of non-verbal behavior in communication between the non-Swedish physicians and their Swedish patients and colleagues to a very limited extent. This was done primarily in relation to word-finding and comprehension problems. It might be interesting to analyze, for example, proxemics, eye contact and haptics in intercultural medical encounters. However, better-quality recordings would be needed to do this, which might be difficult to obtain for ethical reasons. Investigating eye contact in consultations to complement the questionnaire results proved to be complicated, since the extra equipment appeared to disturb the participants. Proxemics is complicated to analyze, as it depends upon external factors (e.g., furniture, the amount of space available in the room, even the presence of camera), which vary in these recordings.

The influence of gender, age and patient education on communication

I did not have enough data to draw definite conclusions concerning the influence of gender on communication in intercultural medical encounters. The same is true of age and education. More data on these issues are needed to draw conclusions. In addition, it might be interesting to find out whether the physician's age influences the interaction.

Particular cultural backgrounds

It is not clear whether the amount of data on which this thesis is based on is great enough to draw definite conclusions concerning the impact of the non-Swedish physicians' cultural backgrounds on their communication with the Swedes. In the thesis, I focused primarily on the non-Swedish physicians as a group, partially ignoring other aspects of their cultural backgrounds. Though I made an attempt to provide some insights into how physicians from different cultural backgrounds communicate, more data and research are needed to analyze different cultures in health care. Unfortunately, at the time of the data collection phase of the project (2003–2004), there were relatively few non-Swedish physicians in Sweden. Today there are more, which will make it possible to analyze how physicians from specific countries (Germany, Hungary, Greece, etc.) communicate with their patients. It might also be interesting to compare non-native physicians in different European countries; the first steps have already been taken within the "Medics on the Move" Project.

Non-Swedish physician–non-Swedish patient communication

This study is an analysis of the non-Swedish physicians communicating with Swedish patients. However, in their daily work, the non-Swedish physicians also have contacts with patients from different cultural backgrounds. Apart from a short article by Kljakovic (2004),

which emphasizes the interest immigrant patients show in consulting with a physician from the same cultural background, who will be better able to understand them in terms of language and their needs, and the fact that some immigrants from different cultural backgrounds than the foreign physician still assume that any foreign physician will understand them and their situation better than a non-foreigner, no studies on foreign physician–foreign patient communication are known to me.

It would also be interesting to find out how the non-native physicians communicate with patients from similar cultural backgrounds. In the project this thesis is based on, a minor study was initiated concerning communication between non-Swedish physicians and their non-Swedish patients (Leis, 2006). The results show that the non-Swedish patients were more likely than Swedish patients to question their physicians' professional competence because of their lack of language competence; this apparent paradox might be rooted in cultural views regarding the importance of physicians' demonstrating their professional competence to patients. Another finding was that patients from the same culture as a non-Swedish physician might require "special" treatment from the physician (i.e., the kind of treatment they are used to in their home country), which the latter might not be able to provide. Interactions between a foreign physician and a foreign patient with a different linguistic and cultural background mediated by an interpreter would also be interesting to look at.

Views on health and disease, outcomes of consultation

We did not specifically address this issue in the project, but the differences between the physicians' and patients' views of health and disease might well influence their relationship.

More detailed analysis of intercultural physician-colleague communication

I have only touched upon a few select issues concerning communication between non-Swedish physicians and Swedish medical personnel. A more detailed analysis is needed to gain better insight into what communication between colleagues with different cultural backgrounds looks like in intercultural Swedish health care.

8.3 Implications for teaching and training

In this section, I will make some recommendations concerning teaching and training for medical personnel (Swedish and non-Swedish). The bases for the recommendations are the empirical data presented in this thesis, studies of the literature and my practical experience in giving lectures on intercultural communication at the Department of Linguistics, University of Gothenburg, and being a guest lecturer for different courses for medical personnel.

Good intercultural training, according to Chen and Starosta (1998), has an influence on the trainee's *cognition*, *affect*, and *behavior*.

Concerning *cognition*, participants are anticipated to develop a better understanding of each other's points of view, use fewer negative stereotypes in thinking about people from different cultures, recognize greater complexity in their own and other people's cultures and develop a "world-minded" attitude as they gain greater knowledge of their own culture (p. 260).

Enjoyment of interacting with people from different cultures, positive expectations concerning the establishment of good relationships with people from different cultures and pleasure in living in a new culture are the components of *affective* intercultural training (p.

260).

Finally, in terms of *behavior*, helping participants to develop better interpersonal relationships in work groups that include members of different cultures and to feel more at ease doing so, to better adjust to the different kinds of stress caused by cultural differences, and to achieve better job performance are the goals we set for ourselves in intercultural communication (p. 260).

All the above-mentioned aspects of intercultural training are useful to apply in training courses. First of all, it is important to draw participants' attention to the issue of communication itself, emphasizing that successful communication with patients and colleagues depends not only on medical knowledge but on adequate communication skills as well, which can be revelation to foreign physicians, as Fiscella and Frankel (2000) point out:

> the IMG [international medical graduates] [come] from the developing countries where epidemic disease, physician shortages, and disparities in education leave little room for the exploration of the patient's story as a focus for clinical training.
>
> (Fiscella and Frankel, 2000, p. 1753)

A training course for health care personnel should provide both *general* knowledge and *specific* knowledge.

The general knowledge should include, among other things, some knowledge of communication, basic knowledge of the theories of intercultural communication research, examples of problems with understanding that arise in intercultural communication, issues of identity, prejudice and discrimination, ethical aspects, power, emotional challenges (i.e., culture shock, as well as reverse cultural shock for physicians/personnel who plan to return to their native countries after working in Sweden), stress and anxiety, conflict and conflict resolution, leadership and intercultural communication, etc. A review of possible language problems with supporting examples can also be very useful.

The specific knowledge comprises an overview of the typical social activities in which the participants, in our case health care personnel, will find themselves participating (e.g., medical consultations, hospital rounds, coffee and lunch breaks, communication with people in different occupational categories, etc.), supported by examples. Attention should be paid to teamwork, which may be a new experience for non-Swedish physicians (see also Hall et al., 2004). The specific knowledge also includes information about Sweden (host culture for the non-Swedish and home culture for the Swedish personnel), as well as some information about the cultures of the various participants. I would recommend that course organizers acquire information about the home cultures of the participants when preparing the course and encourage the participants to compare the patterns of communication in their home countries and in Sweden. In addition, as I have mentioned, special attention should be paid to emotional challenges, such as anxiety and stress, conflict management, and culture shock, which are not uncommon in intercultural encounters.

I outlined some of these recommendations in an EIW project[41] report that later became the basis for a booklet on health care (Allwood et al., 2007). I will briefly summarize them here and present a more complete list, which may be useful for people who are in the same situation as the informants of this study, that is, non-native physicians, Swedish and non-Swedish medical personnel, their patients and their superiors, such as chief physicians, who might be faced with the integration of non-native medical personnel in the workplace.

Recommendations concerning practicality

It has proven to be beneficial if a mentor is provided for each non-Swedish physician when he/she starts working in Swedish health care. The mentor should be a person who is able to assist with both language problems and other problems and properly introduce the new physician to the workplace. Introduction to routines, tips on where and how to find information and a detailed overview of the structure of Swedish health care are essential.

Recommendations concerning language

Language training for non-Swedish health care personnel should include the vocabulary used in the everyday health care practice. I suggest that non-Swedish physicians should be aware of the following aspects, which should be included in language-training courses:

- **Medical terms and their Swedish equivalents**: It is essential to be able to talk to the patient in "ordinary Swedish" – not using Latin or English terms.
- **Tempo of interaction:** Speak slowly and clearly! This is important for both native and non-native speakers to remember in order to enhance the possibility of mutual understanding in an intercultural setting, given that a rapid speech rate in combination with an accent might be problematic for the listener to understand. The personnel should also be aware that elderly patients may have hearing problems.
- **Listening skills, interruptions:** Listen to what your patients and colleagues say! Do not interrupt since you may miss important information; moreover, in Sweden, interruption is impolite and will make a bad impression on the patient/ colleague.
- **Body language:** Be aware of your body language. When necessary, use it to help solve word-finding problems.
- **Problems with understanding:** To the non-Swedish physicians/personnel: If you don't understand someone, say so! Ask the other person to repeat what he/she has just said. Of course, this might be a delicate thing to do given that nobody is eager to display their language problems, but it is better to ask for help than to make mistakes due to lack of understanding/misunderstanding. To the native speakers: have patience, speak slowly and try to understand what is being said.
- **Language learning at work:** It is essential that the non-Swedish physicians/personnel be given opportunities to practice their communication skills. The non-Swedish physicians/personnel should have the opportunity to visit Swedish workplaces during the language course so they can both receive language training and learn the routines. This will prepare them for their future work.

Recommendations concerning differences in communication styles and handling of cultural differences

To start with conflict avoidance, as I have shown in the thesis, the Swedish indirect communicative style and predilection for conflict avoidance can be quite confusing for representatives of cultures used to a more direct communication style. For example, the non-Swedish physicians often report being confused and unsure about what their colleagues and patients think about them. As for directness and expression of emotions, the non-Swedish physicians might be seen as "direct" in a negative way (e.g., *osmidig* ['inflexible']) due to differences in communicative styles as well as their lack of language competence (i.e.,

41. The European Intercultural Workplace Project (2004–2007) funded by the EU Leonardo da Vinci Programme II, is a project intended to highlight key issues for managers, employees and customers from host and immigrant cultures in the public, private and education sectors. Ten European countries were compared to investigate the challenges posed by an increasingly intercultural work environment. For more information, see http://www.eiworkplace.net/.

problems with formulating the message in a less direct way):

- **To the non-Swedish personnel:** Be aware of the above-mentioned features of Swedish culture. Remember that in Sweden it is often poorly thought of to show one's emotions openly.
- **To the Swedish personnel:** Be aware of the above-mentioned features of Swedish culture. Be aware that people express emotions differently in different cultures.
- **To the managers:** If the staff complain about a non-Swedish colleague in terms such as "He is no good!", always ask what is not good. Make the person who complains justify the statement. Try to explain why the problem might have occurred.

Differences in views of power distance and hierarchy are another aspect that should be discussed during training courses for the personnel. Physicians who come from countries where the power distance is larger than in Sweden often expect to be treated with more respect by nurses.

- **To non-Swedish physicians:** Be aware of the differences in hierarchy in Sweden and your country of origin, which might result in different role expectations.
- **To the Swedish personnel:** Be aware of possible differences in communicative styles. Do not take them personally.

Gender roles should be made clear. In other societies, views of male and female roles differ from the Swedish "equality." Swedish personnel need to be aware of this, when communicating with, for example, a male physician whose "direct" style of communication with nurses might be due to differences in power distance rather than to his views of gender roles.

The strong distinction between private and public life in Sweden is an important aspect to introduce to the non-Swedish personnel. Sweden is an individualistic country in many regards and everyone is expected to take care of themselves. Unfortunately, this often results in the non-Swedish physicians' feeling very lonely. Moreover, the fact that your workplace friends may not want to be friends outside the workplace can be frustrating.

Communication with patients, the physician's and patient's roles, and taboo topics should also be covered during language courses. As I have mentioned above, though I did not devote much attention to sensitive topics and differences in views on health and illness, it is important to draw attention to these issues (see, for example, Haines and Browne, 2007). Swedish "cultural diseases" such as *utbrändhet* ('burnout'), *elöverkänslighet* ('electrosensitivity'), and *fibromyalgi* ('fibromyalgia') (Beland, 2003) should be mentioned. It is also beneficial to present specific information concerning the course participants' specializations (e.g., geriatrics, psychiatry, etc.). Knowledge of the other cultures and religions represented in Sweden is also beneficial for the non-Swedish physicians.

Recommendations concerning training techniques

Apart from giving lectures, a variety of techniques commonly used in intercultural training can be applied, such as role playing, case studies, critical incidents, cultural assimilators, simulations, etc. Role plays in which the non-Swedish physicians communicate with their "patients" are useful. It is also beneficial to record them and subsequently watch and analyze the interactions together. Individual feedback for each participant from the supervisor concerning both language and cultural competence is appreciated.

Another tool is to present the participants with recordings of typical situations (scripted scenarios), along with a number of questions for discussion and a manual that illustrates the issues discussed. Examples are *Scener ur ett arbetsliv* and the EIW training materials (Duncan et al., 2007).

Within the project, Jens Allwood, Randi Myhre and I have also developed a number of

scenarios that illustrate issues that are relevant to intercultural communication at the Swedish health care workplace. An example is provided in Appendix F.

Finally, course organizers should be aware of differences in learning styles of representatives of different cultures. As Couser (2007) points out, the representatives of many non-Western cultures are used to being passive receivers of information delivered in didactic styles, which should be taken into consideration in preparing training courses.

8.4 Final words

In this thesis, I have described and analyzed intercultural communication between non-Swedish physicians and their Swedish patients. I have also compared this intercultural communication with monocultural communication, which takes place between Swedish physicians and Swedish patients. Some attention has also been paid to communication between the non-Swedish physicians and their Swedish colleagues. I hope that the results of this study will contribute to a better understanding of physician-patient and physician-colleague communication in general, and intercultural medical communication in particular.

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Appendices

Appendix A. Questionnaires

Kommunikation och interaktion i den mångkulturella vården

Ett samarbete mellan Institutionen för kirurgi, Sahlgrenska Akademin, Kollegium SSKKII, Institutionen för lingvistik, Göteborgs Universitet och Västra Götalandsregionen

Projektets målsättning är att beskriva och analysera tvärkulturell kommunikation mellan läkare med utländsk bakgrund, svenska patienter och annan sjukvårdspersonal för att ta reda på hur personer med olika kulturell bakgrund kommunicerar med varandra. Ett av projektets syften är att genom sådana studier hjälpa till att förbättra språk- och kulturundervisning för icke-svenskspråkig sjukvårdspersonal. För att göra det behöver vi Din hjälp!

Inom ramen för projektet planerar vi att skriva en manual för språk- och kulturundervisning av framtida utländska läkare i Sverige för att de snabbare ska kunna komma ut och börja jobba inom den svenska sjukvården. Din insats i projektet kan hjälpa dem att göra det!

Om Du vill ha mer upplysningar om projektet kan Du ringa till följande personer:

Jens Allwood, *Professor i allmän språkvetenskap, Inst. för lingvistik, tel 031-773 18 76, e-post: jens@ling.gu.se*
Amir Khorram-Manesh, *Vårdenhetsöverläkare, Akut och trauma kirurgi, SU/SS, tel: 031-342 1129/ or 342 1000, e-post: Amir.Khorram-Manesh@surgery.gu.se*
Shohreh Salehinejad*, SU/SS, tel 0701738018, e-post: ssalehinejad@yahoo.com*
Nataliya Berbyuk, *Doktorand, Inst. för lingvistik, tel 031-773 52 13, e-post: natasha@ling.gu.se*
Charlotte Edebäck*, Kollegium SSKKII, tel 031-773 52 13, e-post: charlotte@ling.gu.se*

Questionnaire to the non-Swedish physicians

Projekt
Kommunikation och interaktion i den mångkulturella vården
Ett samarbete mellan Institutionen för kirurgi, Sahlgrenska Akademin, Kollegium SSKKII, Institutionen för lingvistik, Göteborgs Universitet och Västra Götalandsregionen
läkare

1. Bakgrund

1. **Ålder** _____
2. **Kön**
   - ❑ man
   - ❑ kvinna
3. **Ursprungsland**_____
4. **Vad har Du för medicinsk utbildning?**
   _____

5. **Var utbildade Du dig till läkare?**
   - ❑ i hemlandet _____
   - ❑ i Sverige _____
   - ❑ annat land. I så fall vilket?_____

6. **Har Du annan kvalificerad utbildning utöver din medicinska utbildning?**
   - ❑ Ja,_____
     från (land)_____
   - ❑ Nej

7. **Vilket är ditt specialistområde?**
   _____

8. **Var fick Du din specialistexamen?**
   - ❑ i hemlandet
   - ❑ i Sverige
   - ❑ annat land. I så fall vilket?_____

9. **Arbetslivserfarenhet som läkare i ditt hemland (antal år)**_____

10. **Antal år i Sverige** _____

11. **Antal yrkesverksamma år som läkare i Sverige**_____

12. **Vilka språk kan Du utöver ditt modersmål och svenska?**
    _____

13. **Svenskundervisning (antal år)**
    - ❑ i hemlandet _____
    - ❑ i Sverige _____

2. Kommunikation med svenska patienter

14. **Hur upplever Du kommunikationen med svenska patienter?**

a)
- ❑ den kännetecknas av ömsesidig god behärskning av språk och kommunikation
- ❑ den kännetecknas av ömsesidig kulturell förståelse
- ❑ mycket tillfredställande
- ❑ tillfredställande
- ❑ mindre tillfredställande

b) *Om Du svarat ”mindre tillfredställande”, beror det på att det är svårt att:*
- ❑ uttala ord
- ❑ hitta ord
- ❑ bilda meningar
- ❑ se om patienten förstått
- ❑ förstå underförstådd information
- ❑ annat _____

15. Finns det skillnader under konsultation med svenska patienter jämfört med patienter i ditt hemland?
- ❑ Ja
- ❑ Nej
- ❑ *Om ja, skriv gärna vilka*_____

- ❑ *Ingen erfarenhet*

16. Finns skillnader som gäller:
Materiell standard
- ❑ Ja
- ❑ Nej

- ❑ *Ingen erfarenhet*

Förekomst av samtalsrum
- ❑ Ja
- ❑ Nej

- ❑ *Ingen erfarenhet*

17. Familjemedlemmars deltagande i konsultation är:
- ❑ vanligare i Sverige
- ❑ vanligare i mitt hemland
- ❑ lika vanligt
- ❑ lika ovanligt

- ❑ *Ingen erfarenhet*

18. Kommunikationen med patienten påverkas av att familjemedlemmar deltar, den
- ❑ underlättas
- ❑ försvåras
- ❑ har ingen betydelse

19. Får Du hjälp under ditt samtal med svenska patienter av annan vårdpersonal?

- ❑ Ja
- ❑ Nej
- ❑ Ja, ibland

*Om ja, skriv gärna på vilket sätt?*_____
_____

Språkliga svårigheter:

- ❑ att uttala ord
- ❑ att hitta rätt ord
- ❑ att bilda meningar
- ❑ att se om patienten förstått vad du säger
- ❑ att få hjälp att tolka underförstådd information
- ❑ att ge mer detaljerade medicinska beskrivningar till patienten

Svårigheter att tolka patienten gällde:

- ❑ patientens önskemål om behandling
- ❑ patientens förväntningar på konsultationen
- ❑ patientens symptombeskrivningar

Annat_____
_____

Med aktivitet menar vi i detta fall att patienten deltar aktivt i samtalet genom bl a ställa många frågor, kräva detaljerade förklaringar från läkaren, ifrågasätta läkarens behandlingsbeslut, osv. Med passivitet menas här dess motsats.

20. Är svenska patienter jämfört med patienter i ditt hemland?

- ❑ mer passiva
- ❑ mindre passiva
- ❑ ingen skillnad

- ❑ *ingen erfarenhet*

21. Av svenska patienter är:

- ❑ kvinnor mer passiva
- ❑ män mer passiva
- ❑ ingen skillnad

22. Av patienter från ditt hemland är:

- ❑ kvinnor mer passiva
- ❑ män mer passiva
- ❑ ingen skillnad

- ❑ *ingen erfarenhet*

23. Finns det skillnader i hur patienter pratar med dig i Sverige och i ditt hemland?

- ❑ Ja
- ❑ Nej

Om ja, skriv gärna vilka?
_____
_____

- ❑ *ingen erfarenhet*

24. Har din samtalsstil vid konsultation med patienter i Sverige förändrats jämfört med hur den var i hemlandet:

- ❑ har blivit mer informell
- ❑ har blivit mer formell
- ❑ oförändrad
- ❑ annat_____
  _____

- ❑ *ingen erfarenhet*

25. I kommunikation med svenska patienter har missförstånd förekommit:

- ❑ Ja, ofta
- ❑ Ja, ibland
- ❑ Sällan
- ❑ Nej, aldrig

Berodde patientens missförstånd på att Du hade svårighet att:

- ❑ uttala ord
- ❑ hitta rätt ord
- ❑ bilda meningar
- ❑ se om patienten förstått vad jag säger
- ❑ få hjälp att tolka underförstådd information
- ❑ ge mer detaljerade medicinska beskrivningar till patienten

Om Du upplevt missförstånd gällde svårigheten:

- ❑ patientens önskemål om behandling
- ❑ patientens förväntningar på konsultationen
- ❑ patientens symptombeskrivningar

Annat_____
_____
_____
_____

26. Hjälper patienterna till vid språkliga problem?

- ❑ Ja
- ❑ Nej
- ❑ Ibland

*Om ja, på vilket sätt?*_____

27. I ditt möte med svenska patienter som utländsk läkare upplever Du att de visar:

- ❑ tålamod
- ❑ intresse
- ❑ irritation
- ❑ tolerans
- ❑ nervositet
- ❑ uppgivenhet
- ❑ nyfikenhet
- ❑ Annat_____

28. Har Du upplevt att patienter förväxlat din språkkompetens med din yrkeskompetens?

- ❑ Ja
- ❑ Nej
- ❑ Ibland

29. Vad tycker Du är viktigast vid första mötet med en ny patient? *(Du kan kryssa för flera alternativ)*

- ❑ att visa ett genuint intresse för patienten
- ❑ att skapa en personlig relation
- ❑ tilltala vid förnamn
- ❑ lösa patientens problem
- ❑ ögonkontakt
- ❑ tillit
- ❑ lugn
- ❑ förtroende
- ❑ visa sin yrkeskompetens
- ❑ hälsa, genom handskakning
- ❑ att lyssna
- ❑ ta patientens upplevda problem på allvar
- ❑ annat_____
  _____

30. Som läkare i Sverige i jämförelse med ditt hemland har Du mötts av:

- ❑ mer respekt
- ❑ mindre respekt
- ❑ ingen skillnad

- ❑ *ingen erfarenhet*

31.Skiljer sig synen på tid åt i Sverige och i ditt hemland?

- ❑ Svenska patienter vill ha längre konsultationer
- ❑ Svenska patienter vill ha kortare konsultationer
- ❑ Ingen skillnad

- ❑ *Ingen erfarenhet*

32.Har problem i kommunikationen mellan dig och patienter uppstått när Du tagit upp ämnen som är tabubelagda i Sverige men inte i ditt hemland?

- ❑ Ja
- ❑ Nej

Om ja, vilket ämne gällde det?

_____

3. Kommunikation med svenska kollegor

33.Skillnader mellan överordnade och underordnade är?

- ❑ större i Sverige
- ❑ mindre i Sverige
- ❑ ingen skillnad

34.Hur uppfattar Du din kommunikation med svenska kollegor?

- ❑ tillfredställande
- ❑ mindre tillfredställande
- ❑ kännetecknas av ömsesidig god behärskning av språk och kommunikation
- ❑ kännetecknas av ömsesidig kulturell förståelse
- ❑ annat_____
  _____

35.I din kommunikation på arbetsplatsen i Sverige jämförelse med ditt hemland är du:

I förhållande till:	*Mer informell*	*Mindre informell*	*Ingen skillnad*
Chefen	❑	❑	❑
Sjuksköterskor	❑	❑	❑
Andra läkare	❑	❑	❑
Patienter	❑	❑	❑

- ❑ *ingen erfarenhet*

36. Vid problem eller frågor <u>angående patienter</u> vänder Du dig i första hand till:

- ❑ chefen
- ❑ andra utländska läkare på arbetsplatsen (om det finns några)
- ❑ andra svenska läkare
- ❑ sjuksköterskor
- ❑ annan sjukvårdspersonal
- ❑ tar själv reda på det Du behöver

37. Vid problem eller frågor <u>angående kollegor</u> vänder du dig i första hand till:

- ❑ chefen
- ❑ andra utländska läkare på arbetsplatsen (om det finns några)
- ❑ andra svenska läkare
- ❑ sjuksköterskor
- ❑ annan sjukvårdspersonal
- ❑ tar själv reda på det Du behöver

38. När det gäller andra drag i kommunikation, har Du upplevt att det:

- ❑ kan uppstå missförstånd i kommunikation med kollegor
- ❑ är svårt att förstå kollegor
- ❑ är svårt att uttala ord
- ❑ är svårt att hitta ord
- ❑ är svårt att sätta ihop ord i meningar
- ❑ är svårt att se om kollegan förstått
- ❑ är svårt att förstå underförstådd information

39.I mötet med svenska medarbetare är det viktigt att: *(Du kan kryssa för flera alternativ)*

- ❑ undvika konflikter
- ❑ vara indirekt
- ❑ vara neutral
- ❑ inte utmärka sig
- ❑ fika ihop, ta kafferaster
- ❑ annat_____

Finns det något annat vi borde uppmärksamma i kommunikation mellan icke-svensk läkare och svenska patienter och kollegor?

Skriv gärna!

TACK FÖR DIN MEDVERKAN!!

Questionnaire to the Swedish patients

Kommunikation och interaktion i den mångkulturella vården

Ett samarbete mellan Institutionen för kirurgi, Sahlgrenska Akademin, Kollegium SSKKII, Institutionen för lingvistik, Göteborgs Universitet och Västra Götalandsregionen

Om du <u>inte</u> har erfarenhet av samtal med utländska läkare vid läkarbesök, behöver Du <u>inte</u> fylla i enkäten. Tack för visat intresse!

På flertalet frågor går det bra att kryssa för mer än ett alternativ, lycka till!

<u>1. Bakgrund</u>

1. Ålder _____

2. Kön ☐ man ☐ kvinna

3. Ditt Ursprungsland_____

4. Vad har Du för utbildning?

- ❑ grundskola
- ❑ gymnasieutbildning
- ❑ högskoleutbildning/ universitetsutbildning
- ❑ annat_____

<u>2. Erfarenhet av samtal med utländska läkare vid läkarbesök</u>

Vi är ute efter läkare som har kommit till Sverige i vuxen ålder och som fått sin utbildning i hemlandet.

Besvara följande frågor (5, 6, 7) med kryss för "ja" eller "nej" samt " Hur säker är du på din bedömning?"

Fråga		Svar		Hur säker är du på din bedömning?		
		Ja	Nej	Mycket säker	Relativt säker	Mycket osäker
5	**Har Du träffat någon sådan läkare?**					
6	**Kom läkaren hit i vuxen ålder?**					
7	**Hade han/hon fått sin utbildning i hemlandet?**					

8. Läkaren kom ifrån (land)_____

- ❑ *vet ej*

9. Läkaren var: ☐ man ☐kvinna

10. Hur fick Du reda på att läkaren inte var svensk?

- ❑ från sjuksköterskan/annan sjukvårdspersonal:
  - o före läkarbesöket
  - o efter läkarbesöket
- ❑ läkaren sade det till Dig
- ❑ Du frågade läkaren
- ❑ Du gissade på:
  - o läkarens namn
  - o läkarens brytning
  - o läkarens utseende
  - o annat_____

11. Vilket var läkarens specialistområde? (ex. ortoped, allmänläkare, narkosläkare)
*Skriv gärna*_____

12. Var ägde läkarbesöket rum?

- ❑ vårdcentral
- ❑ sjukhus
- ❑ privat mottagning
- ❑ annat_____

13. Hur upplevde Du ert samtal?

a)

- ❑ mycket tillfredställande
- ❑ tillfredställande
- ❑ mindre tillfredställande
- ❑ inte tillfredställande

b)

Om Du svarat "mindre/inte tillfredställande," berodde det på att läkaren:

- o var svår att förstå
- o hade svårt för att uttala vissa ord
- o hade svårt för att hitta ord
- o hade svårt för att bilda meningar
- o hade svårt att se om Du hade förstått

14. Var Du nöjd med läkarbesöket med hänsyn till Dina förväntningar?

a)

- ❑ ja
- ❑ nej

b) Om nej, vad berodde det på?

- o språkliga svårigheter
- o kulturella skillnader, vilka_____
  _____
- o både språkiga svårigheter och kulturella skillnader
- o annat_____
  _____
  _____

15. Var annan sjukvårdspersonal närvarande vid ert samtal?

- ❑ ja
- ❑ nej

16. Fick läkaren stöd under ert samtal av annan sjukvårdspersonal?

- ❑ ja
- ❑ nej

Om ja, vem var det som hjälpte till?

- o svensk läkare
- o annan utländsk läkare
- o sjuksköterska
- o undersköterska
- o annan_____

Vad gällde hjälpen?

Språkliga svårigheter:

- o att uttala ord
- o att hitta rätt ord
- o att bilda meningar
- o att se om Du förstått vad han/hon sa
- o att tolka underförstådd information
- o att ge en mer detaljerad medicinsk beskrivning till Dig

Svårigheter för läkaren att tolka vad Du sade gällde:

- o Dina önskemål om behandling
- o Dina förväntningar på läkarbesöket
- o Dina symptombeskrivningar
- o annat_____
  _____
  _____
  _____

17. Hjälpte Du till vid eventuella språkliga problem?

a)

- ❑ ja
- ❑ nej

b) Om ja, vad gällde hjälpen?

Språkliga svårigheter:

- o att uttala ord
- o att hitta rätt ord
- o att bilda meningar
- o att se om Du förstått vad han/hon sa
- o att tolka underförstådd information
- o att ge en mer detaljerad medicinsk beskrivning till Dig

Svårigheter för läkaren att tolka vad Du sade gällde:

- o Dina önskemål om behandling
- o Dina förväntningar på läkarbesöket
- o Dina symptombeskrivningar
- o annat_____
  _____
  _____

18. Uppstod missförstånd i ert samtal?

- ❑ ja
- ❑ nej

Om ja, på vilket sätt?

*Skriv gärna*_____
_____

19. Var det något under ert möte som tydde på kulturella skillnader?

Med "kultur" menar vi här skillnader i uttryck, beteende och förhållningssätt, värderingar, attityder, kroppsspråk, osv.

- ❑ ja
- ❑ nej

Om ja*, skriv gärna*_____
_____
_____
_____
_____

20. Vad upplevde Du som positivt i besöket?
*skriv gärna*_____
_____
_____
_____

21. Fick Du tillräckligt med förklaringar?
- ❑ ja
- ❑ nej

_____
_____
_____

22. Vilken känsla hade Du under ert möte?
Visade Du:
- ❑ tålamod
- ❑ intresse
- ❑ irritation
- ❑ tolerans
- ❑ nervositet
- ❑ uppgivenhet
- ❑ nyfikenhet
- ❑ annat_____

_____

3. Generellt om kommunikation med utländska läkare och om eventuella skillnader mellan utländska och svenska läkare

I den här sektionen ber vi Dig jämföra dina erfarenheter av kommunikation med utländska läkare med Dina erfarenheter av kommunikation med svenska läkare.

23. Vad tycker Du är viktigast vid första mötet med en läkare?
Att läkaren:
- ❑ visar ett genuint intresse för Dig
- ❑ skapar en personlig relation
- ❑ tilltalar vid förnamn
- ❑ löser Dina problem
- ❑ har ögonkontakt
- ❑ visar tillit
- ❑ är lugn
- ❑ inger förtroende
- ❑ visar sin yrkeskompetens
- ❑ hälsar, genom handskakning
- ❑ lyssnar
- ❑ tar Dina upplevda problem på allvar
- ❑ annat_____

24. Anser Du att utländska läkare jämfört med svenska läkare förväntar sig att bli bemötta med:
- ❑ mer respekt
- ❑ mindre respekt
- ❑ ingen skillnad

- ❑ *vet ej*

25. Påverkar en utländsk läkares språkkunskaper Ditt första intryck av hans/hennes:
- ❑ yrkeskompetens
- ❑ professionalitet
- ❑ förmåga att göra Dig trygg
- ❑ kapacitet att förstå Dig
- ❑ ingen påverkan
- ❑ annat_____

_____
_____

26. Har Du upplevt att samtalstiden med utländska läkare är:
- ❑ längre än med svenska läkare
- ❑ kortare än med svenska läkare
- ❑ ingen skillnad

- ❑ *vet ej*

27. Har Du upplevt att utländska och svenska läkare ställer frågor på olika sätt, ex. mer eller mindre direkta frågor?
- ❑ ja
- ❑ nej

Om ja*, skriv gärna*_____
_____
_____
_____
_____
_____
_____

□ *vet ej*

I frågan nedan avses med "aktiv samtalspartner" ett aktivt deltagande i samtalet genom bl a ställa många frågor, be om detaljerade förklaringar, ifrågasätta, kommentera, osv. Med passivitet menas här motsatsen.

28. Vilken typ av läkare upplever Du som mest aktiv som samtalspartner?

- ❑ svenska kvinnliga läkare
- ❑ svenska manliga läkare
- ❑ utländska kvinnliga läkare
- ❑ utländska manliga läkare
- ❑ ingen skillnad

- ❑ *vet ej*

Med "auktoritär läkare" i frågan nedan menar vi en läkare som dominerar samtalet och som fattar beslut om behandling utan eller med endast lite inflyttande från patienten.

29. Vilken typ av läkare upplever Du som mest auktoritär?

- ❑ svenska kvinnliga läkare
- ❑ svenska manliga läkare
- ❑ utländska kvinnliga läkare
- ❑ utländska manliga läkare
- ❑ ingen skillnad

- ❑ *vet ej*

30. Anser Du att utländska läkares samtalsstil jämfört med svenska läkare är:

- ❑ mer informell
- ❑ mer formell
- ❑ ingen skillnad
- ❑ annat_____
  _____
  _____
  _____

- ❑ *vet ej*

Finns det något annat vi borde uppmärksamma i kommunikationen mellan utländska läkare och svenska patienter?
Skriv gärna!

TACK FÖR DIN MEDVERKAN!

Questionnaire to the Swedish health care personnel

Projekt
Kommunikation och interaktion i den mångkulturella vården
Ett samarbete mellan Institutionen för kirurgi, Sahlgrenska Akademin, Kollegium SSKKII, Institutionen för lingvistik, Göteborgs Universitet och Västra Götalandsregionen
Svensk sjukvårdspersonal

1. Bakgrund

1. **Ålder** _____
2. **Kön**
   - ❑ man
   - ❑ kvinna

3. **Vad har Du för medicinsk utbildning?**
_____

4. **Var utbildade Du dig?**
   - ❑ i Sverige
   - ❑ annat land. I så fall vilket?_____

5. **Vilket är ditt specialistområde?**_____
_____

6. **Antal yrkesverksamma år inom svensk sjukvård** _____

7. **Vilka språk kan Du utöver ditt modersmål?**
_____
_____

2. Kommunikation med svenska patienter

8. **Vad tycker Du är viktigast vid första mötet med en ny patient?**

(Du kan kryssa i flera alternativ.)

- ❑ visa ett genuint intresse för patienten
- ❑ skapa en personlig relation
- ❑ tilltala vid förnamn
- ❑ lösa patientens problem
- ❑ ha ögonkontakt
- ❑ visa tillit
- ❑ vara lugn
- ❑ ge förtroende
- ❑ visa sin yrkeskompetens
- ❑ hälsa, genom handskakning
- ❑ lyssna
- ❑ ta patientens upplevda problem på allvar
- ❑ annat_____
_____

9. **Kommunikationen med patienten påverkas av att familjemedlemmar deltar, den**
   - ❑ underlättas
   - ❑ försvåras
   - ❑ har ingen betydelse

   - ❑ *ingen erfarenhet*

Med aktivitet menar vi i detta fall att patienten deltar aktivt i samtalet genom att bl a ställa många frågor, kräva detaljerade förklaringar från läkaren, ifrågasätta läkarens behandlingsbeslut, osv. Med passivitet menas här dess motsats.

10. **Av patienter är:**
- ❑ kvinnor mer passiva
- ❑ män mer passiva
- ❑ ingen skillnad

11. **Vilka ämnen uppfattar Du som tabubelagda i kontakten med svenska patienter?**
_____
_____

3. Erfarenhet av kommunikation med utländska läkare

12. **Har Du erfarenhet av kommunikation med utländska läkare?**
    - ❑ Ja
    - ❑ Nej

Om ja, kommer Du ihåg varifrån läkarna kom? I så fall skriv gärna_____

- ❑ Ja, Jag har erfarenhet av kommunikation med kvinnliga utländska läkare
- ❑ Ja, Jag har erfarenhet av kommunikation med manliga utländska läkare

4. Kommunikation med utländska läkare

13. **Hur uppfattar Du din kommunikation med utländska läkare, den**
- ❑ är tillfredställande
- ❑ är mindre tillfredställande
- ❑ kännetecknas av ömsesidig god behärskning av språk och kommunikation
- ❑ kännetecknas av ömsesidig kulturell förståelse
- ❑ annat_____
_____

14. **Utländska läkares syn på skillnader mellan överordnade och underordnade är:**
- ❑ större än svenska läkares
- ❑ mindre än svenska läkares
- ❑ ingen skillnad

- ❑ *ingen erfarenhet*

15. Upplever Du att utländska läkare, vid problem eller frågor <u>angående patienter,</u> i högre utsträckning än svenska läkare vänder sig till:

- ❑ chefen
- ❑ andra utländska läkare på arbetsplatsen (om det finns några)
- ❑ andra svenska läkare
- ❑ sjuksköterskor
- ❑ annan sjukvårdspersonal
- ❑ tar själv reda på det de behöver

16. Upplever Du att utländska läkare, vid problem eller frågor <u>angående kollegor,</u> i högre utsträckning än svenska läkare vänder sig till:

- ❑ chefen
- ❑ andra utländska läkare på arbetsplatsen (om det finns några)
- ❑ andra svenska läkare
- ❑ sjuksköterskor
- ❑ annan sjukvårdspersonal
- ❑ tar själv reda på det de behöver

17. När det gäller andra drag i kommunikationen, har Du upplevt att det:

- ❑ kan uppstå missförstånd i kommunikation med utländska läkare
- ❑ är svårt att förstå utländska läkare
- ❑ är svårt att se om utländska läkare förstått
- ❑ är svårt för utländska läkare att förstå underförstådd information

18. I mötet med svenska medarbetare är det viktigt att:
(Du kan kryssa i flera alternativ)

- ❑ undvika konflikter
- ❑ vara indirekt
- ❑ vara neutral
- ❑ inte utmärka sig
- ❑ fika ihop, ta kafferaster
- ❑ annat_____
  _____

19. Tror Du att en utländsk läkares dåliga språkkunskaper kan förväxlas med dåliga yrkeskunskaper?

- ❑ Ja
- ❑ Nej

20. Tror Du att synen på respekt skiljer sig åt mellan utländska läkare och svenska läkare?

- ❑ Ja
- ❑ Nej
- ❑ Om ja, skriv gärna på vilket sätt?
  _____
  _____

21. Utifrån din erfarenhet anser Du att manliga utländska läkare jämfört med kvinnliga utländska läkare är:

Manliga utländska läkare är	Mer	Mindre	*Ingen skillnad*
Flexibla	❑	❑	❑
Auktoritära	❑	❑	❑
Sociala (på arbetsplatsen)	❑	❑	❑
Aktiva	❑	❑	❑
Direkta (i sin kommunikation)	❑	❑	❑
Konflikträdda	❑	❑	❑

22. Har problem i kommunikationen mellan dig och utländsk läkare uppstått när läkaren tagit upp ämnen som är tabubelagda i Sverige men inte i hans/hennes hemland?

- ❑ Ja
- ❑ Nej

Om ja, vilket ämne gällde det?
_____
_____

23. Har problem i kommunikationen mellan dig och utländsk läkare uppstått när <u>Du</u> tagit upp ämnen som är tabubelagda i hans/hennes hemland men inte i Sverige?

- ❑ Ja
- ❑ Nej

Om ja, vilket ämne gällde det?
_____
_____

Finns det något annat vi borde uppmärksamma i kommunikation mellan icke-svensk läkare och svenska patienter och kollegor?

Skriv gärna på baksidan!

TACK FÖR DIN MEDVERKAN!!

Appendix B. Consent form for video recording

Medgivande till videofilmning av läkarbesök

Projektet *"Kommunikation och interaktion i den mångkulturella vården"* (Inst. för Lingvistik, Göteborgs Universitet) undersöker hur utländska läkare kommunicerar och interagerar i den svenska sjukvården. Vi studerar hur människor med olika kulturell bakgrund kommunicerar vid bl a läkarbesök, och om det uppstår några problem därvid.
Ett av projektets syfte är att genom denna studie hjälpa till att förbättra språkundervisning för icke-svenskspråkig sjukvårdspersonal.

För att nå kunskap om hur utländska läkare fungerar (kommunikativt) i den svenska sjukvården – gentemot både svenska och utländska kollegor och patienter – kommer vi att göra intervjuer, kassett- samt videoinspelningar. Vi kommer även att studera hur svenska läkare och svenska patienter kommunicerar, i syfte att jämföra dessa kategorier.

Vi kommer bl a att videofilma läkarbesök. Inga intima kroppsundersökningar kommer att filmas och videofilmen kommer enbart att ses av dem som är engagerade i projektet. Inga uppgifter som talar om vilka försökspersonerna är, kommer att föras vidare och medverkan är helt anonym.

Om Ni vill ha mer upplysningar om projektet ber vi Er kontakta Jens Allwood (tel 031-7731876), Nataliya Berbyuk, (tel 031-7735213) vid Institutionen för Lingvistik, eller Charlotte Edebäck (tel 031-7732983) vid Kollegium SSKKII, Göteborgs Universitet.

Var vänlig kryssa för ett av alternativen nedan:

Jag har muntligen informerats om studien och har tagit del av ovanstående information. Jag är medveten om att mitt deltagande i studien är helt frivilligt och att jag när som helst och utan närmare förklaring kan avbryta mitt deltagande. Om jag ångrar mig efter en intervju eller videoinspelat läkarbesök och vill att filmen ska raderas, kommer detta att utföras.

- □ **Ja, jag medger att dagens läkarbesök får videofilmas.** Jag är införstådd med att inspelningen efteråt endast kommer att användas av de som är engagerade i projektet. Jag är även införstådd med att jag kan begära att filmen raderas efter konsultationen.
- □ **Nej, jag vill inte att dagens läkarbesök videofilmas.**

Namnteckning:_____

Ort och datum:_____

Appendix C. Overview of recordings of medical consultations

Detailed information about the recordings of medical consultations is presented in Tables 1 to 4 below. First, the recordings in the ICCMedConsult corpus (made between 2003 and 2005) are presented, followed by the recordings in the SweMedConsult corpus (made between 1989 and 2005).

Hungarian group

Table 1: Recordings of medical consultations: Hungarian group

Information about the recordings			Background information about the participants					
Type/ number	Title	Length (min)	Physicians			Patients		
			Code	Age	Gender	Code	Age	Gender
VHu[1]1	Athroscopy	08.23	HuD1	45	male	HuD1P1	21	female
VHu2	Driving after surgery	07.20				HuD1P2	47	male
VHu3	Rather good ECG	12.42	HuD2	34	female	HuD2P3	72	female
VHu4	Tumour like a flower	15.47				HuD2P4	84	female
VHu5	Strange feeling	13.37	HuD3	36	male	HuD3P5	80	female
VHu6	Not old patient	25.15				HuD3P6	76	male
VHu7	Teetotaler	20.04				HuD3P7	74	male
VHu8	Memories	16.29				HuD3P8	72	female
VHu9	Slipped disk	09.33	HuD4	44	male	HuD4P9	52	male
AHu10	Varicose veins	05.45				HuD4P10	47	female
VHu11	Caring for a disabled child	08.46				HuD4P11	45	female
VHu12	Sports and knee problems	10.14				HuD4P12	30	male
Total: 12 recordings (11 video and 1 audio), total recording time: 2 hrs 34 min, mean time: 13 min								

1. V=video, A=audio; Hu=Hungarian, D=physician; P=patient

Iranian group

Table 2: Recordings of medical consultations: Iranian group

Information about the recordings			Background information about the participants					
Type/ number	Title	Length (min)	Physicians			Patients		
			Code	Age	Gender	Code	Age	Gender
VIra[2]13	Bend plastic	35.21	IraD6	49	female	IraD6P13	45	male
AIra14	Sore throat	04.54	IraD7	40	female	IraD7P14	16	female
AIra15	Urinary infection	08.43				IraD7P15	28	female
VIra16	Bullet	21.01	IraD8	45	male	IraD8P16	47	male
VIra17	Cyst	13.20				IraD8P17	54	female
VIra18	A lot of sweat	14.00				IraD8P18	33	male
VIra19	Eye drops	06.12	IraD9	48	male	IraD9P19	60	male
VIra20	Hobby drummer	10.21				IraD9P20	58	male
VIra21	Annoying examination	11.52				IraD9P21	68	female
VIra22	Working abroad	13.57				IraD9P22	52	male
VIra23	Cataract surgery	11.54				IraD9P23	79	female
VIra24	Reading glasses	07.35				IraD9P24	24	male
VIra25	Feeling good	11.53	IraD10	50	female	IraD10P25	70	female
VIra26	Sick list	17.06				IraD10P26	59	female
VIra27	Christmas holliday	09.59				IraD10P27	60	female
Total: 15 recordings (13 video and 2 audio), total recording time: 3 hrs 18 min; mean time: 13.2 min								

Mixed Group

Table 3: Recordings of medical consultations: Mixed group

Information about the recordings			Background information about the participants					
Type/ number	Title	Length (min)	Physicians			Patients		
			Code	Age	Gender	Code	Age	Gender
VMix28	Pain in hands	62.30	GerD12	56	male	GerD12P28	37	female
VMix29	Unstable spine	44.36				GerD12P29	39	male
VMix30	Gallbladder	13.14	ColD17	39	male	ColD17P30	79	female
VMix31	All eater	04.57				ColD17P31	47	female
VMix32	Tired woman	16.59	RusD19	45	female	RusD19P32	89	female
VMix33	Shoulder	21.31				RusD19P33	82	male
VMix34	Politician	10.55	YugD20	35	female	YugD20P34	49	male
Total: 7 video recordings, total recording time: 2 hrs 55 min, mean time: 25 min								

2. Ira=Iranian

Swedish group

Table 4: Recordings of medical consultations: Swedish group

Information about the recordings			Background information about the participants					
Type/ number	Title	Length (min)	Physicians			Patients		
			Code	Age	Gender	Code	Age	Gender
ASwe35	Knee	10.23	SweD1	30–45	male	SweD1P35	76	female
ASwe36	Radiation control	07.53				SweD1P36	61	male
ASwe37	Claudication control	09.14				SweD1P37	78	female
ASwe38	Caries	12.30	SweD2	30–45	male	SweD2P38	82	female
ASwe39	Borrelia	14.00				SweD2P39	67	male
ASwe40	Sleepingpills	17.00				SweD2P40	73	female
ASwe41	Stomach	11.50				SweD2P41	26	female
ASwe42	Erysipelas	11.45				SweD2P42	81	female
ASwe43	Gout	04.00				SweD2P43	70	male
ASwe44	Angina	15.00				SweD2P44	67	male
ASwe45	Cold	05.21				SweD2P45	38	female
ASwe46	Trip to Bahamas	15.00				SweD2P46	54	female
ASwe47	Clot	18.00	SweD3	30–45	male	SweD3P47	75	male
ASwe48	Metabolism	11.48				SweD3P48	67	male
VSwe49	Cold stomach	05.38	SweD4	40	male	SweD4P49	75	male
VSwe50	Shrimps and eggs	10.55				SweD4P50	69	female
VSwe51	Spring runner	05.54	SweD5	27	male	SweD5P51	38	female
VSwe52	Weight problems	08.30				SweD5P52	47	female
VSwe53	Trip to Thailand	09.13				SweD5P53	68	male
VSwe54	Different appetite	16.39				SweD5P54	74	male
VSwe55	Lymph nodes	06.22	SweD6	50	female	SweD6P55	34	female
VSwe56	Certificate of illness	09.20				SweD6P56	53	male
VSwe57	Pilates	25.33				SweD6P57	28	female
VSwe58	High blood pressure	16.54				SweD6P58	61	female
VSwe59	Removed gallbladder	15.08	SweD7	33	female	SweD7P59	70	female
VSwe60	Ostomy	08.55				SweD7P60	82	female
VSwe61	Horse riding	10.35				SweD7P61	42	female
VSwe62	Bladder	18.13				SweD7P62	68	female
VSwe63	Infection	20.44				SweD7P63	66	male
Total: 29 recordings (15 video and 14 audio), total recording time 6 hrs 3 min; mean time: 12.5 min								

Appendix D. Survey participants

This appendix contains information about the participants involved in the survey.

Survey participants: Non-Swedish physicians

Table 5: Information on the non-Swedish physicians who participated in the survey

Participants' codes	Country of origin	# of participants	Age range	Gender		Specialties	Work as physicians		Time in Sweden (years, shotest - longest)	Language training (years)	
				m	f		in home country (years, shortest-longest)	in Sweden (years, shortest-longest)		in home country (years, shortest-longest)	in Sweden (years, shortest-longest)
Region: Western Europe; Country: Germany											
GerD23–D51	Germany	29	29–54	18	11	anesthesiology, dermatology, general practice, geriatrics, internal medicine, neuropathology, ophthalmology, pediatrics, psychiatry	>1–18	>1–4.5	>1–4.5	0	>1–2
Region: Central Europe; Country: Hungary											
HunD52–D63	Hungary	12	34–48	8	4	anesthesiology, pathology, cytology, intensive care, ophthalmology, radiology	>1–24	>1–2.5	>1–2.5	>1–2.5	>1–1
Region: Northern Europe; Countries: Iceland, Finland											
IslD64–D69	Iceland	6	32–44	4	2	endocrinology, pulmonary medicine, orthopedics	1–3.5	>1–17	>1–17	0	0
FinD70	Finland	1	39	0	1	orthopedics	7	6	6	6	0
Region: Countries: former Yugoslavia (Bosnia, Macedonia, Serbia)											
BosD71–D73	Bosnia	3	35–52	0	3	general practice	>1–16	4–6.5	5–12	0	1–7.5
MacD74	Macedonia	1	42	1	0	psychiatry	>1	11	15	0	3
SerD75	Serbia	1	39	0	1	internal medicine	1.5	7	10	0	3
Region: Mediterranean; Countries: Greece, Italy, Spain											
GreD76–D78	Greece	3	28–41	3	0	internal medicine, orthopedics	>1–6	>1–6	>1–6	0.5	0
ItaD79	Italy	1	32	1	0	general practice	2	2	2	0	>1
SpaD80–D83	Spain	4	32–38	3	1	general practice	3-8	4–5	4–5	>1	>1
Region: Baltic States and Eastern Europe; Countries: Latvia, Lithuania, Poland, Romania, Czech Republic											
LatD84	Latvia	1	35	0	1	general practice	3	4	4	>1	3
LitD85	Lithuania	1	38	1	0	anesthesiology	12	2	2.5	0	3

PolD86–88	Poland	3	30–57	2	1	anesthesiology, geriatrics, internal medicine	>1–10.5	1–16	1–20	>1	3
RomD89-D91	Rumania	3	38-43	0	3	geriatrics, internal medicine	>1–3	>1–10	2.5–14	0	2
CzeD92-D93	the Czech Republic	2	37-47	2	0	anesthesiology, radiology	10–20	2–3	2–3	0	2
Region: Middle East; Countries: Iraq, Iran, Syria, Lebanon											
IraqD9–D96	Iraq	3	31–41	2	1	gynecology, internal medicine, obstetrics	>1–5	>2–8	>2–12	0	2–3
IraD97-D101	Iran	5	33-48	5	0	internal medicine, ophthalmology, ortopedics	>1–5	2–16	16–21	0	2–3
SyrD102	Syria	1	46	1	0	general practice	3	7	8	0	3
LibD103	Lebanon	1	35	1	0	internal medicine	>1	2	2	0	3
Region: Western Europe; Country: Belgium											
BelD104	Belgium	1	30	1	0	general practice	>1	2	2	0	>1
Region: Latin America; countries; Argentina, Colombia											
ArgD105	Argentina	1	45	0	1	pulmonary	9	13	14	0	1
ColD106	Colombia	1	39	1	0	surgery	2	10	12	0	2
Region: Asia; country: China											
ChiD107	China	1	40	1	0	cardiology	4	6	13	0	2
Total: 85 physicians, 55 male and 30 female											

Survey participants: Swedish physicians and Swedish health care personnel

Table 6: Overview of survey participants: Swedish physicians and health care personnel

Participant code	Occupation category	Number of participants	Age range (years)	Gender		Specialties	Working experience (years)
				m	f		
SweD10–14	physician	6	20–50	4	2	anesthesiology, intensive care, orthopedics, thoracic surgery, none	4–15
SweN5–49	nurse	54	20–60	7	47	anesthesiology, nephrology, orthopedics, thoracic surgery, ophthalmology, none	>4–38
SweAN 6–25	assistant nurse	26	20–60	0	26	cardiology, pulmonary medicine, nursing, ophthalmology, orthopedics, rheumatology, surgery, none	2–36
PersPhys 1–11	physiothera pist	12	3–40	1	11	cardiology, geriatrics, intensive care, pulmonary medicine, orthopedics	3–40
PersAssis 1–9	care assistant laboratory assistant	10	20–60	3	7	clinical chemistry, nephrology, nursing, pharmacy, thoracic surgery	3-35
Total: 6 physicians, 102 other health care personnel							

Survey participants: Swedish patients

Table 7: Overview of survey participants: Swedish patients

Participant code	Gender		Age range (years)	Education
	m	f		
P73–P79		7	20–90	primary
P80–94		15	20–90	secondary
P95–112		18	20–70	post-secondary
P113–120	8		50–80	primary
P121–136	16		20–90	secondary
P137–P157	20		20–70	post-secondary
Total: 84 patients, 44 male and 40 female				

Appendix E. Questionnaire data. Swedish patients (age, gender, education)

Table 8: Satisfaction with communication (Q.13a)

Question/ Gender / Age group Education	Alternatives/number and % of resp.ondents per alternative									
	M					F				
How did you experience your conversation [with the non-Swedish physician]?	Alternatives				# of resp.	Alternatives				# of resp.
	Very satisfied	Satisfied	Less satisfied	Un satisfied		Very satisfied	Satisfied	Less satisfied	Un satisfied	
Age and gender										
20-50	9 35%	12 46%	5 19%	0 0%	26	7 24%	11 38%	7 24%	4 14%	29
51-90	11 61%	5 28%	2 11%	0 0%	18	7 64%	1 9%	1 9%	2 18%	11
Education and gender										
primary	7 88%*	1 13%	0 0%	0 0%	8	3 43%	2 29%	2 29%	0 0%	7
secondary	5 21%	7 44%	4 25%	0 0%	16	4 27%	7 47%	1 7%	3 20%	15
post-secondary	8 42%	8 42%	3 16%	0 0%	19	7 38%	4 21%	5 26%	3 16%	19
*The numbers do not add up to 100% because of rounding.										

Table 9: Satisfaction with consultation with regard to expectations and explanations provided by the non-Swedish physicians (Q.14a and 21 respectively)

Question/ Gender / Age group Education	Alternatives/number and % of resp.ondents per alternative					
	M			F		
Were you satisfied with the consultation with regard to your expectations?	Alternatives		# of resp.	Alternatives		# of resp.
	Yes	No		Yes	No	
Age and gender						
20-50	22 85%	4 15%	26	20 69%	9 31%	29
51-90	17 94%	1 6%	18	8 73%	3 17%	11
Education and gender						
primary	8 100 %	0 0%	8	6 86%	1 14%	7
secondary	13 81%	3 19%	16	10 67%	5 33%	15
postsecondary	18 90%	2 10%	20	10 56%	8 44%	18

Question/ Gender / Age group Education	Alternatives/number and % of resp.ondents per alternative					
	M			F		
Did you get enough with explanations?	Alternatives		# of resp.	Alternatives		# of resp.
	Yes	No		Yes	No	
Age and gender						
20-50	22 85%	4 15%	26	17 71%	7 29%	24
51-90	17 94%	1 6%	18	11 79%	3 21%	14
Education and gender						
primary	8 100%	0 0%	8	6 86%	1 14%	7
secondary	13 81%	3 19%	16	12 80%	3 20%	15
postsecondary	17 89%	2 11%	20	10 63%	6 37%	16

Table 10: Swedish patients: cultural differences in interaction with non-Swedish physicians (Q.19)

Question/Gender	**Alternatives/number and % of resp.ondents per alternative**				**Number of resp.ondents**			
Age group/ Education	**M**				**F**			
Did something occur in your meeting [with the non-Swedish physician] that indicates cultural differences?	**Alternatives**			**# of resp.**	**Alternatives**			**# of resp.**
	Yes	No	if yes, please comment		Yes	No	if yes, please comment	
Age and gender								
20-50	2 8%	23 92%	0 0%	25	7 32%	14 64%	1 5%	22
51-90	2 12%	15 88%	0 0%	17	3 23%	10 8%	4 31%	13
Education and gender								
primary	0 0%	6 100%	0 0%	6	1 17%	5 83%	0 0%	6
secondary	2 13%*	14 84%	0 0%	16	5 38%	7 54%	1 8%	13
postsecondary	2 10%	18 90%	0 0%	20	4 25%	12 75%	4 25%	16
*The numbers do not add up to 100% because of rounding.								

Table 11: Difference in communicative style between Swedish and non-Swedish physicians (Q. 30)

Gender/ Age group/ Question	**Alternatives/number and % of resp.ondents per alternative**											
	M						**F**					
Do you think that non-Swedish physicians' communicative style, compared to Swedish physicians' communicative style, is	**Alternatives**					**# of resp.**	**alternatives**					**# of resp.**
	More informal	More formal	No difference	Other	Don't know		More informal	More formal	No difference	Other	Don't know	
Age and gender												
20-50	4 16%	6 24%	8 32%	2 8%	5 20%	25	4 17%	6 26%	7 30%	0 0%	6 26%	23
51-90	0 0%	3 16%	12 63%	1 5%	3 16%	19	0 0%	4 29%	8 57%	0 0%	2 14%	14
Education and gender												
primary	0 0%	2 25%	5 63%*	0 0%	1 13%	8	0 0%	0 0%	5 83%	0 0%	1 17%	6
secondary	3 19%	3 19%	9 56%	0 0%	1 6%	16	2 13%	4 27%	5 33%	0 0%	4 27%	15
postsecondary	1 5%	4 20%	6 30%	3 15%	6 30%	20	2 13%	6 38%	5 21%	0 0%	3 19%	16
*The numbers do not add up to 100% because of rounding.												

Table 12: Misunderstandings in communication with non-Swedish physicians (Q.18)

Question/ Gender	Alternatives/number and % of resp.ondents per alternative			Number of resp.ondents		
Age group Education	M			F		
Did misunderstandings occur in your conversation [with the non-Swedish physician] ?	Alternatives		# of resp.	Alternatives		# of resp.
	Yes	No		Yes	No	
Age and gender						
20-50	3 12%	23 88%	26	6 21%	23 79%	29
51-90	1 6%	17 94%	18	4 37%	8 73%	11
Education and gender						
primary	0 0%	7 100%	7	1 17%	5 83%	6
secondary	4 25%	12 75%	16	6 40%	9 60%	15
postsecondary	0 0%	20	20	3 19%	13 81%	16

Table 13: Help with language problems to non-Swedish physicians (Q.17a)

Question/ Gender	Alternatives/number and % of resp.ondents per alternative					
Age group Education	M			F		
Did you help the non-Swedish physician with language problems?	Alternatives		# of resp.	Alternatives		# of resp.
	Yes	No		Yes	No	
Age and gender						
20-50	3 12%	22 88%	25	9 36%	16 64%	25
51-90	5 29%	12 71%	17	4 36%	7 64%	11
Education and gender						
primary	0 0%	6 100%	6	2 33%	4 67%	6
secondary	3 19%	13 81%	16	7 54%	6 46%	13
postsecondary	5 25%	15 75%	20	4 24%	13 76%	17

Table 14: Language competence and professional competence (Q.25)

Gender/	Alternatives/number and % of resp.ondents per alternative						Number of resp.ondents					
Age group/ Education	M						F					
Does the non-Swedish physician's language competence influence your first impression of his/her ...	Alternatives					# of resp.	Alternatives					# of resp.
	Professional competence	Professionalism	Ability to make me feel secure	Ability to understand me	No influence		Professional competence	Professionalism	Ability to make me feel secure	Ability to understand me	No influence	
Age and gender												
20-50	1 4%	1 4%	10 42%	12 50%	9 38%	24	4 16%	4 16%	9 36%	12 48%	10 40%	25
51-90	2 11%	3 17%	2 11%	5 28%	11 61%	18	1 7%	0 0%	3 20%	6 40%	6 40%	15
Education and gender												
primary	0 0%	1 13%	0 0%	1 13%	4 50%	6	0 0%	0 0%	1 14%	3 43%	4 57%	7
secondary	2 13%	1 6%	5 21%	5 21%	9 56%	16	3 27%	3 20%	7 47%	6 40%	5 33%	15
post-secondary	1 5%	2 10%	7 35%	11 55%	7 35%	20	2 11%	1 6%	4 22%	9 50%	6 33%	18

Table 15: Difference in questioning between non-Swedish and Swedish physicians (Q. 27)

Question/Gender	Alternatives/number and % of resp.ondents per alternative							
Age group/ Education	m				F			
Have you found that non-Swedish and Swedish physicians ask questions in different ways (i.e., more or less direct questions)?	Alternatives			# of resp.	alternatives			# of resp.
	Yes	No	Don't know		Yes	No	Don't know	
Age and gender								
20-50	7 29%	15 63%	2 8%	24	8 32%	14 56%	3 12%	25
51-90	2 10%	13 65%	5 20%	20	1 7%	11 73%	3 20%	15
Education and gender								
primary	2 25%	6 75%	0 0%	8	1 14%	6 86%	0 0%	7
secondary	3 19%	11 69%	2 13%	16	5 33%	7 47%	3 20%	15
post-secondary	4 20%	11 55%	5 25%	20	3 17%	12 67%	3 17%	18

Appendix F. Example of scene

Example of training material: scene "Hänger smockan i luften?" ("Are they almost coming to blows?")

INT 1.: Korridor på avdelningen. Eftermiddag

Utländsk läkare från Grekland (Demetrios 40 år)
Utländsk läkare från Irak (Said 46 år)

Vi ser en lång ljus sjukhuskorridor med britsar, dörrar till patienternas salar. Från personalrummet kommer Said och träffar Demetrios, som kommer ut ur en sal. Demetrios ser trött men glad ut. Said hälsar på Demetrios.

Said
- Hej du klar för dagen går du hem nu
Demetrios
- Ja, ja. Jag ska resa till Kanarieöarna imorgon. Det blir skönt att vila lite Jag åker med min fru och min son
Said
- Det låter bra. Det är varmt och regnar inte som här. Det är ju fint och mycket sol i våra hemländer eller hur? (ler paus) du den patient Sune Larsson kommer du ihåg honom han med grått hår
Demetrios
-Ja jag hade honom förut men han är din patient han som är lite speciell (vinkar med handen) eller
Said
-Ja ja men du han ska skrivas ut och du hade honom länge kan du göra det
Demetrios
-Nej du jag ska hem nu du hade honom hela tiden (höjer rösten)
Said
-Ja men du hade honom också
Demetrios
- Du jag går hem nu. Jag är trött som hund och ska inte sitta med det här du hade ju honom sist du du förstår jag på väg hem Jag åker imorgon
Said
- Men du …
(diskussionen pågår – de pratar högt och gestikulerar vilt)

INT 2. Längre borta i korridorren
svensk sjuksköterskor Pernilla, Gunilla och en rysk sjuksköterska Masha 29 år

Pernilla
- Oj ser du! De skriker ju på varandra! Vad ska patienterna säga? Tänk om de ryker ihop också! Nåt måste göras. Vi måste nog säga till Ulrika om detta!
Gunilla
- Vad menar du? Nej då det kommer de inte göra. De pratar högt bara de diskuterar och är arga på varandra
Masha
- Ingenting konstigt. Hemma i Ryssland pratar vi högt också och kan skrika. Jag tror inte att de ska slå varandra
Pernilla
- Jaså… så gör man inte i Sverige
(i bakgrunden: samtalen mellan läkarna pågår och mer och mer folk dras dit)