

Communicative Construction of Native versus Non-Native Swedish Speaking Patients in Consultation Settings

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Abstract

In this paper, we examine patient-centered care through analyzing communicative constructions of patients, on the basis of their native language, in consultations with physicians. Whereas patient-centered care is of current interest in health care, research has not addressed its implications in this dimension. Previous studies indicate that non-native Swedish speaking patients, experience substandard interpersonal treatment far more than native Swedish speaking patients. Our findings show that the non-native Swedish speaking patients presented themselves as participating, whereas the native Swedish speaking patients presented themselves as amenable. The physicians responded in two different ways, argumentatively towards the non-native Swedish speaking patients and acknowledging vis-à-vis the native Swedish speaking patients. When decisions and conclusions were made by the patients and physicians, this resulted in preservation of the status quo in the consultations with the non-native Swedish speaking patients, while the corresponding result with the native Swedish speaking patients was monitoring of their health status. So, whereas the non-native Swedish speaking patients actually were model patient-centered care patients, physicians were more amenable towards the native Swedish speaking patients. We suggest that patient-centered care is desirable, but its practical application must be more thoroughly scrutinized from both a patient and a health care worker perspective.

Introduction

The purpose of this study is to explore how native versus non-native Swedish speaking patients are verbally constructed in consultations with physicians, and to discuss the findings in the context of patient-centered care¹. Patient-centered care is a key dimension of quality in Swedish health care, which is demonstrated by the explicit support given in the Health and Medical Services Act (Swedish Statute Book, 1982) and other policy documents from The National Board of Health and Welfare (e.g., 2009). However, compared to other quality dimensions, there is a lack of research on what patient-centered care entails and in the research and evaluation done, the concept has primarily been examined from a homogenous perspective, neglecting for instance multicultural aspects (The Swedish Agency for Health and Care Services Analysis, 2012).

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Equal care is also a quality dimension in Swedish health care and is closely linked to patient-centered care (Engebretson, Mahoney, & Carlson, 2008; Mayberry, Nicewander, Qin, & Ballard, 2008; Saha, Beach, & Cooper, 2008). Braveman and Gruskin (2003) stress that health care and its institutions are facing challenges to identify and overcome obstacles that disadvantage certain groups from receiving full benefits of health care. Language, racism and prejudiced assumptions are seen as barriers that must be further examined in order to address and reduce the disparities. Ahlberg and Krantz (2006) stress that research has already clarified that immigrant patients receives subordinate care and the next step is to examine how the existing discrimination can be understood and explained.

This study responds to Braveman and Gruskin's (2003) suggestion to examine how language, racism and prejudiced assumptions obstruct equality and to Ahlberg and Krantz's (2006) call to further explain existing discrimination. The study complements previous research on patient/health care worker communication and on patient-centered care; it contributes with a qualitative perspective on dialogue in health care settings, and it clarifies how unequal treatment may be shaped and expressed based on the patient's native language.

Individualization of health care – double motives

The ideas of patient-centeredness dates back to the late 1960s. Central to patient-centered care is that patients are regarded as unique and it contains a specific approach to how health care workers should communicate with patients (Saha et al., 2008). Mead and Bower (2000) found five dimensions influencing the patient-centeredness; professional context, doctor factors, patient factors, consultation-level and "shapers". This notion of communication and interpersonal encounters as anything but isolated phenomena, constituted an ideological and patient-friendly motive and a contrast to the hitherto prevailing "disease-centered medicine". During the last decade, in an era of health care consumerism, patient-centered care has increased its popularity greatly, with health administrators and policy makers embracing the idea (Charmel & Frampton, 2008). The earlier phraseology with the patient's perspective and participation in focus has gradually been replaced by terms emphasizing efficiency (Pestoff, 2006; Wasson, Godfrey, Nelson, Johnson, & Batalden, 2007) and patient responsibility (Cahill, 1998).

This second motive derives from a lack of accessibility to health care and patient sensitivity, as well as concerns that systems do not promote the cost-effective production of services. The fiscal crisis of the 1990s accentuated the need to improve health care productivity and efficiency (Jonsson, Agardh, & Brommels, 2006). In response to that, New Public Management (Hood, 1991) spread as an ideology. The ideals espoused by New Public Management brought a change in mindset regarding both the patient and the health care professional, wherein they are required to promote themselves or become entrepreneurs of the

self (Du Gay, 2000). The patient perspective was hereby complemented with patient responsibility.

Unequal care, failure to communicate and the rebirth of patient-centered care

Previous research indicates that today's health care in Sweden has deficiencies with regard to equality and multicultural aspects (Diaz, 2009; The National Board of Health and Welfare, 2011; Swedish Government Official Reports, 2006). The problem is not, however, specifically Swedish. In an overview of health care research in the UK, well-functioning communication was found to be especially important in respect of the needs of members of cultural, linguistic or migrant minorities, but that communication with these patients has such extensive shortcomings that it is seen as the main cause of future inequalities. The consequences of communicative deficiencies tend to increase over time and shift from being interpersonal to become clinical (Szczepura et al., 2005). Patients experiencing communicative deficiencies may also receive older and less effective medications (Diaz, 2009) and immigrants tend to experience more verbal domination and less patient-centeredness (Johnson, Roter, Powe, & Cooper, 2004). In addition, ethnic minorities have less contact with health services (Swedish Association of Local Authorities and Regions & The National Board of Health and Welfare, 2011) and receive less information when in contact with them (Abrams, 2004). Recent analyses of national patient surveys in primary care and hospital services show that those whose native language is not Swedish feel less informed, respected and involved than native Swedish speakers. Moreover, patients with immigrant backgrounds give worse reviews on treatment, information and participation in care compared to native Swedes (The National Board of Health and Welfare, 2011). Other studies show correlations between perceived discrimination and mental and physical illness among immigrants in Sweden (Groglopo, 2006). Together, these data indicate that unequal treatment and discrimination in health care on multicultural grounds are, unfortunately, not uncommon in Sweden or elsewhere and that institutions and health care administrators and providers need address these injustices.

Accordingly, numerous concepts such as patient-centered care have been promoted, partly in response to these requirements and partly for the economic reasons mentioned earlier. Such concepts imply a new "modern" understanding of patients as more knowledgeable – for instance, in terms of educational level and awareness of patient rights – and thereby more deserving or better suited to influence and take responsibility for their own treatment (Miracle, 2011). What these concepts stand for is a greater notion of the individual patients' perspectives and the assumption that active involvement of the patient increases the quality of care (Committee on Quality of Health Care in America, 2001; Sidani, 2008). Studies also suggest that patient-centered care may even decrease racial bias (Beach, Rosner, Cooper, Duggan, & Shatzer, 2007; Engebretson et al., 2008), thereby adding a third motive for patient-centered care as being effective

from an equality perspective as well. However, there is still some concern that there is a lack of support for this sort of patient responsibility and for all it should entail, and in the end, the discourse of involvement and decision-making are at risk of becoming nothing but a discourse of non-existing choices tending to disempower the once empowered (Fotaki, 2011).

Discrimination in health care is thus well documented. Previous research has pointed to the role of unconscious assumptions in discriminatory behavior (e.g., Burgess, van Ryn, Dovidio, & Saha, 2007; Dovidio et al., 2008; van Ryn & Fu, 2003), but so far, research on communication is mainly limited to quantitative aspects, such as the percentage of distributed statements between health care professionals and patients, so-called verbal dominance (e.g., Cooper et al., 2012; Siouta, Broström, & Hedberg, 2012; Street, Gordon, & Haidet, 2007). The same applies for research on patient-centered care with an overwhelming predominance on speaking space percentages (Bertakis & Azari, 2010; Cooper et al., 2003; Johnson et al., 2004; Vaccaro & Huffman, 2012) rather than highlighting the concepts constructing and constitutive features, which further paves the way for this study.

Theoretical perspective

The theoretical point of departure is social constructionism, which incorporates an understanding of human identity and social positions as socially and linguistically constructed (Berger & Luckmann, 1966). Consequently, the “core of human” cannot be reduced to the individual’s alignment with one or several social positions (de los Reyes, Molina, & Mulinari, 2006) such as gender, native language, et cetera. In the present article, the term non-native Swedish speaking patient is understood as socially defined differences based on physical characteristics, culture, and historical domination and oppression, justified by entrenched beliefs (Acker, 2006), meaning that it is something *ascribed*, something socially and communicatively constructed, rather than an expression of individual characteristics.

Essed (2005) discusses how different concepts are used to describe some groups as “the other” based on their affiliation with a different “cultural background” or “ethnicity”. The concept of non-native Swedish speaking patient is surrounded by the same problem. Therefore, we want to emphasize that when we categorize individuals into the “non-native Swedish speaking patient group”, this is done solely for the purpose of examining how patient-centered care manifests itself in different ways for different patient groups. In order to visualize this, and, most importantly, how these differences can manifest themselves, the focus is on perhaps the only thing shared by the former patient group - namely, the fact that they do not have Swedish as their native language and are thereby made “other” (Essed, 2005). Thus, understandings and assumptions about the non-native Swedish speaking and native Swedish speaking patients are mediated through language, and any cultural context provides a limited amount of linguistic catego-

ries available for identity construction of oneself and others (Berger & Luckmann, 1966).

Given that the present interest is patient participation in patient-centered care from a qualitative perspective, the reciprocal communicative constructions between patients and physicians in consultation settings becomes central. Linell's *dialogism* (2009) provides a valuable and specific take on communication and dialogue, wherein communication is distinguished as *monologically* and *dialogically* organized. The former means to consider communication as a context-independent act between a transmitter and a receiver and to highlight the language structure. In the latter understanding, communication is a social interaction, meaning that social conditions such as, native language, are seen as influencers of the contextual communicative conditions rather than as stable categorizations. The monological perspective is here understood as an expression of substandard patient-centered care, whereas the dialogical is understood as more compatible with patient-centered care.

The dialogical perspective consists of three principles influencing the degree of dialogue. First, *sequentiality* means that statements are seen as influenced by their positions in sequences of statements rather than as individual acts. Thus, in a dialogue, statements are linked to both previous and future statements. Second, *joint construction* implies that meaning is mutually constructed in communication rather than simply transmitted. Third, *act-activity interdependence* means that statements co-constitute each other, Statements are situated within an embedding activity (dialogue in this case), which is jointly produced by the participants (Linell, 2009). Besides being organized monologically or dialogically, communication is influenced by discourses – a specific way of understanding or representing an object (in this case patients as non-native or native Swedish speaking) is given preference and thereby creates a certain social or discursive order (Fairclough, 2001; Linell, 2009).

Method

Setting and participants

Data² was collected between June and December, 2009 at four hospitals in southern Sweden with established, nurse-based outpatient clinics for patients with Atrial Fibrillation. The hospitals were selected based on location, size and number of treated patients with Atrial Fibrillation. We use eleven tape-recorded consultations with physicians. There were two consultations with non-native Swedish speaking patients, and nine with native Swedish speaking patients.

The two non-native Swedish speaking patients, a man and a woman, come from different parts of the world, the Middle East and Eastern Europe. While one patient masters the Swedish language smoothly, the other patient uses an interpreter. One of them was 76 years old, and the other 55 years old. The mean age of the native Swedish speaking patients was 76.4, the youngest was 55. Other social positions, like sex/gender, class and so on may also be relevant. Regarding sex/gender, differences were found but revolved mainly around variations in

how male and female patients described their condition and the corresponding expectations from the health care workers. As for aspects relevant for the present paper, the patients' sex/gender seemed less significant. As for other categories such as class, sexual orientation et cetera we have no information. The eleven patients first agreed to participate via telephone and arriving at the clinics, they first received an information letter about the procedures and later the physicians introduced them to the third author who obtained written consent to tape the consultation. No patients declined. One of the non-native Swedish speaking patients and two of the native Swedish speaking patients were accompanied by their spouses during the consultations.

Five physicians at four different hospitals consenting to participate received written information about the study. Each physician performed one to four consultations. The duration of the consultations ranged between 20 and 38 minutes (median 25 minutes). The consultations were tape-recorded. The researcher was not present. The consultations were then transcribed, which generated 87 pages of text.

Analysis

We use the framework of critical discourse analysis (Chouliaraki & Fairclough, 1999) to identify and categorize communicative patterns in the empirical data. Fairclough's (1995) conceptualization of three dimensions of discourse as *text*, *discourse practice* and *socio-cultural practice* served as a basic analytical tool by which verbally communicated assumptions about non-native and native Swedish speaking patients were structured and organized (see Table 1 below).

The first dimension, discourse as text, concerns how the text represents and produces social identities and relations. In our study, we studied patterns of how patient-centered care is manifested through examining communicative construction of non-native and native Swedish speaking patients from the patient's own statements. The second dimension, discourse practice, deals with the conditions for production (or consumption) of text. Fairclough stresses that different genres have different rules for their production. We look at consultations as a particular genre that health care professionals produce and for which they have acquired the rules of production. We analyze what discourses the health care professionals draw upon when responding to or asking the patients questions, looking for any patterns of how patient-centered care is manifested differently towards the two patient groups. In this way, the health care workers' communication sets the conditions for the production of patient-centered care directed towards non-native and native Swedish speaking patients.

The third dimension is socio-cultural practice. This concerns the implications of discourse in a social and cultural context (Fairclough, 2001) and thus, this dimension results from the former two. We study it by analyzing the summarizing statements and conclusions made by the patients and the physicians. We reflect upon the implications for health care practice and ask if the discursive order is reproduced and/or if there is room for challenging it.

We started by reading the texts three times, with focus on identifying communicative patterns. The following categories emerged: 1) patients presenting themselves and relating to the consultations in two different ways; 2) health care workers responding and relating to the consultations in two different ways; 3) consultations being summarized and concluded in two different ways. These findings were then analyzed using Fairclough's framework. In the text dimension, two dichotomous discourses representing the communicative constructions of the patients were identified. This was done by searching for communicative patterns in the patient's own statements. In the discourse practice dimension, we concentrate on how the physicians related to the patients' statements and identified two prevalent discourses being drawn upon. Finally, the social practice dimension was analyzed and two additional discourses were identified. These final two discourses consist of summaries and conclusions made in the consultations and are the product of the former two discourse dimensions. Summaries and conclusions were made in two opposite ways – one predominantly for the non-native Swedish speaking patients and one predominantly for the native Swedish speaking patients – with potentially different social consequences not only for the patients but also for health care. Whereas Fairclough's text dimension usually concerns written text, we instead analyze verbal communication and therefore complement the analysis with Linell's (2009) three dialogical principles explained earlier. Fairclough is used strictly to categorize the findings. In order to move away from Fairclough's macro perspective and get closer to the participants and to the actual verbal communication, Linell's perspective is used.

Trustworthiness

Shenton (2004) presents four concepts that are important for qualitative research, and we draw on these in order to clarify the trustworthiness of the study. The *credibility* of the study is provided by giving a clear overview of the phenomenon of unequal care health care in reference to communication, multicultural aspects and patient-centered care. This detailed view of the phenomenon, together with an extensive description of the context and the actual implementation of the study, increases the opportunities for comparisons to be made and thereby the *transferability* of the results along with the *dependability* of the study. Finally, the previous theoretical section highlights the point of departure for the interpretation of the empirical material. Our assumptions and outlook on communication, together with the study's limitations, are presented in order to increase its *confirmability*.

Limitations

The study has some limitations, for instance concerning the number of consultations. More consultations with non-native Swedish speaking patients could have given a more comprehensive view. This could have reduced the impact that affiliation to other social positions – such as age and class – might have had on the consultations. Despite these limitations, the findings of this study indicate that it would be worthwhile to conduct further research covering a larger number

of non-native Swedish speaking patients to explore more in depth how patient-centered communication may vary depending on the patient group involved.

Ethical consideration

The study obtained ethical approval by the Regional Ethics Committee in Linköping, Sweden (Dnr. M8-09). The approved application took into consideration issues such as research aim, potential practical applications, confidentiality for patients and staff, selection of participants, data collection, relations between researchers and staff/participants, analysis method, security and risks.

Results

Table 1. Overview of discourses and excerpts

Discourse dimension	Discourse	Excerpt number	Health care workers p*	Patient NNS** NS***
1. Text	1a. The participating patient	1	P 1	NNS1
		2	P 2	NNS2
	1b. The amenable patient	3	P 3	NS1
		4	P 2	NS2
2. Discourse practice	2a. The argumentative physician	1	P 1	NNS1
		2	P 2	NNS2
	2b. The acknowledging physician	3	P 3	NS1
		4	P 2	NS2
3. Social practice	3a. Preservative	5	P 1	NNS1
		6	P 2	NNS2
	3b. Monitoring	7	P 4	NS3
		8	P 3	NS4

* P (physician)

** NNS (Non-Native Swedish speaking patient)

*** NS (Native Swedish speaking patient)

The findings consist of three discourse dimensions with two dichotomous discourses in each dimension (see Table 1). The first two dimensions, representing the patients' statements and the physicians' responses to these statements, are analyzed under the first subsection below. This enables a study of the joint con-

struction of the patients through sequentiality of statements. We illustrate each discourse with excerpts from two physician-patient consultations. Several of the excerpts consist of multiple parts from specific consultations in order to establish the existence of the phenomenon highlighted. In other excerpts, it is only one long part. In order to clarify, the different parts are marked a, b, c, et cetera in the excerpt tables. After the two excerpts are presented, they are analyzed separately and then together, using Linell's abovementioned framework, to further describe the different discourses.

The reciprocal construction of the patient

The first two discourse dimensions represent the communicative construction of the patient, the first from the patient's perspective and the second from the physician's perspective. The basis for the analysis was the patients' presentation of themselves through various statements, followed by the physicians' verbal responses. Four discourses were identified: *the participating patient discourse* versus *the amenable patient discourse* in the text dimension, and *the argumentative physician discourse* versus *the acknowledging physician discourse* in the discourse practice dimension. In the consultations with the non-native Swedish speaking patients, the "participating patient discourse" was drawn upon 12 times, whereas in the consultations with native Swedish speaking patients it was drawn upon 4 times. The "amenable patient discourse" was drawn upon 2 times in the consultations with the non-native Swedish speaking patients, but 23 times in the consultations with the native Swedish speaking patients. Consequently, the participating non-native and native Swedish speaking patients construct themselves differently from a communication point of view. Regarding the physicians' perspective, the consultations with the non-native Swedish speaking patients saw "the argumentative discourse" being drawn upon 15 times, whereas in the consultations with the native Swedish speaking patients it was drawn upon 2 times. The "acknowledgement discourse" was drawn upon 1 time in the consultations with the non-native Swedish speaking patients, but 29 times in the consultations with the native Swedish speaking patients. Consequently, the participating physicians used different ways to communicate towards the two patient groups.

The participating patient and the argumentative physician

The discourse of the participating patient is reflected in statements by the patients signaling dissatisfaction regarding previous experiences of substandard care or regarding the ailment itself. The patients present themselves as reluctant to accept the state of affairs; rather, they express their demands and expectations. The discourse of the argumentative physician is reflected in communication with argumentative features: The physicians argue against the patients and their statements repeatedly. In the excerpt below (Table 2), the patient makes requests to the physician, and the physician contradicts the patient regarding drug treatment.

Table 2. Excerpt 1

Line	Speaker	Utterance
A40	NNS1*	[...] I get stiff, I can't move. That was the main reason I wanted to get rid of Waran.
A41	P1**	Mm. But you have not felt the fibrillation over the last...
A42	NNS1	No.
B47	P1	But, but, what they're discussing today – because before we have always been very keen to get rid of Waran if one sees, if we see that it's okay – eh, now it's discussed very much that once a person has had fibrillation, the question is, should the person continue with Waran? We're still stopping it from time to time, I have to admit ...
B48	NNS1	Yes, you really must do that.
B49	P1	And there's going to be a lot of discussion about that it's often the patient who doesn't want Waran. And I mean, you are especially knowledgeable, so I mean, you know much more what is...
B50	NNS1	When I came here last year, sorry to interrupt, but when I got here, I receive Waran or Trombyl. I was here seven days over Easter and my husband came one night at two o'clock at night to ask, can't I get at least one shot of Heparin?
B51	P1	Mm mm.
C116	NNS1	IP1 – Don't you think I should take Digoxin?
C117	P1	Well, that's nothing that's...
C118	NNS1	You're the doctor, you have to say! [...]

* NNS1 (Non-Native Swedish speaking patient 1)

** P1 (physician 1)

The patient sets the agenda for the conversation, requiring a response from the physician concerning treatment with Waran (48). The sequentiality and the joint construction is characterized by recognition from the physician that the drug is sometimes excluded in the treatment (47), later legitimated by patients often preferring not to take it (49). In the statement, the physician argues for using Waran (47), which the patient previously argued against (40). The physician hints of new knowledge that has come to light. This could/should lead to a questioning of the earlier advice to discontinue the medication. Shortly thereafter, the patient interrupts the physician (50) when the latter complements the patient regarding the patient's knowledge about medication (49). The patient interjected that the decision to exclude medication during the most recent hospital stay was made by the health care workers, which was followed by mumbling from the physician. At the end of the excerpt, the patient makes a call for a decision to be made by the physician concerning another medicine (118). It starts with the patient asking a straight question of whether a certain drug should be taken (116) and is met by an answer from the physician that is not as direct (117). The sequentiality and the joint construction also signal an act-activity interdependence consisting of the two parties' reinforcing effect on one another and their respective statements. The patient's standpoint on Waran (40), the interruption of the physician (50) and the two requests made to the physician

(48:118) are constituted by and constitute the physician's contradicting statements on Waran (47:49) and the fact that the physician's formulation of a response regarding another medication does not meet the patient's expectations (117).

Table 3. Excerpt 2

Line	Speaker	Utterance
A5	NNS2A*	Maybe one does that after a while of being on it, but he has gone several months.
A6	P2**	Right, therefore one could discuss whether you might be able to reduce yours, but now it's not that we're planning a new cardioversion, or?
A7	NNS2A	We haven't heard anything but that's what we want to ask about.
B11	NNS2A	Yes it's been awhile again since my husband... after the cardioversion, when they looked at him again, they did the ultrasound again of the heart again, I think.
B12	P2	Exactly, we'll see if we can find that, it should say that you have done an ultrasound on the heart, right?
B13	NNS2***	Yes.
B14	P2	It was a very long time ago.
B15	NNS2	Yes.
C34	NNS2A	What happens with cardioversion?
C35	P2	[...] It's not so dangerous to have fibrillation as long as it doesn't go too fast. If you can keep down the speed and keep it at an okay rate, if you also feel good, it's usually not a big deal. [...] The fibrillation itself is not a big deal, as long as you feel good. You can skip the cardioversion because there's always a small risk with cardioversion, because it means using anesthesia, every time someone is put to sleep there is a small risk [...] When we look now, you had this left ventricular function and it's a little lower. That can sometimes be due to the fibrillation, it looks like this when they do the exam because the heart went a little too fast. I'll see how fast it went when you did it last time. Then it went much more slowly, so it has actually gotten a little better now the last time.
C36	NNS2A	IP2A - But the heart rate was lower earlier.
C37	P2	Yes it was lower last time when you were examined in April than now. I still think it looked like this left ventricular function was perhaps a little better now than it was last time, and this might also be confirmed by the fact that you feel like you are feeling pretty good.
D171	NNS2A	It's strange that the ultrasound shows 110.
D172	P2	But it may be just, but it may be stress. It may be just what you were doing right then.

* NNS2A (Non-Native Swedish speaking patient 2 attendant)

** P2 (physician 2)

In the excerpt in Table 3, the patient and the accompanying attendant express dissatisfaction with the length of time between examinations. The physician gives an explanation of why a cardioversion is unnecessary, followed by a defusing comment on the increasing fibrillation in the patient.

The sequentiality and joint construction consists of statements from the patient and the accompanying attendant concerning delays (5:7:11:15) and cardioversion (36:171), interspersed by the physician's questioning (4:6:35:37:172) and more neutral replies (10:12:14). The argumentative approach from the physician is expressed in statements regarding whether or not the patient should be given cardioversion (35). The argument is that fibrillation itself is not a particularly dangerous ailment, as long as its speed is not too fast. Later it was revealed that the speed of the fibrillation was lower in previous measurements (36). This was dismissed on the grounds that the left ventricular looked slightly better compared to last time (37). Further into the consultation, the high rate showed in the ultrasound was similarly dismissed on the grounds that it could have been due to stress (172). As in the previous excerpt, the act-activity is characterized by contradictive standpoints between the two parties. The patient and the accompanying attendant's repeatedly emphasizing the long delays as problematic (5:7:11:15) and their questioning of the physician's take on cardioversion (36:171) are constituted by and constitute the physician's dismissal of both cardioversion (35) and the high rate of the ultrasound (172). The patients in these two excerpts exercise their right to occupy an intransigent attitude when it appears necessary for them. They express clear demands and expectations regarding the physician (excerpt 1) as well as the medical treatment (excerpt 2). The physicians disagree. In each case, the communicative construction of the patient as participating is fueled by the simultaneous construction of the physician as argumentative.

The amenable patient and the acknowledging physician

The discourse of the amenable patient is made up of statements from the patients signaling gratitude regarding the state of things and their experience of health care. The patients present themselves as patient and yielding. The discourse of the acknowledging physician is made up of statements where the physicians confirm the patients' statements. Whether the patients' statements are soothing or dramatic, the response tends to be accommodating. In the excerpt below (Table 4), the patient describes the general condition as so good that a neglect of diabetes is possible. The physician tends to approve of the patient's lifestyle, even though it might involve a health hazard.

The sequentiality and joint construction is constituted by the patient expressing contentment regarding the health condition to such an extent that another disease is forgotten (60) and misbehavior is possible (62). The physician dutifully warns the patient (63:65), but after the patient modifies the extent of misbehavior (64), the physician encourages a "semi-misbehaving" lifestyle and empowers the patient's viewpoint by emphasizing the importance of not succumbing to the disease but maintaining some pleasure in life (71). The act-activity, in contrast to the previous two excerpts, is characterized by consensus and mutual reconciliation. The patient first acknowledges the physician by adapting the story of misbehaving (64) after the physician points out the inappropriateness of such (63). Then the opposite occurs as the physician acknowledges the patient's pre-

vious statement that the lifestyle issue is not so strict (68) by partially undermining the previous lifestyle-related warnings and instead emphasizing the need not to overstate the restraints (71).

Table 4, excerpt 3

Line	Speaker	Utterance
A60	NS1*	I feel so good, it's almost like I forget that I have diabetes.
A61	P3**	Well congratulations – that's how it should be!
A62	NS1	Even though I misbehave.
A63	P3	That's not how it should be.
A64	NS1	Well, no, I don't.
A65	P3	Yes, because, yes, because it's clear that...
A66	NS1	Well, a little bit.
A67	P3	Because if we say....
A68	NS1	It's not so strict.
A69	P3	Nah, no right, but at the same time, you have to get it down.
A70	NS1	Yes.
A71	P3	It's like, of course you can't live like a monk, because then you'll end up just lying in bed.

* NS1 (Native Swedish speaking patient 1)

** P3 (physician 3)

In the following excerpt, (Table 5) the patient expresses gratitude for a referral suggested by the physician and lets the physician's perception control the reaction of the fact that the fibrillation has returned. The physician answers with accommodating and caring statements.

The sequentiality and joint construction are manifested through the patient's repeatedly expressing gratitude towards the physician (142:152) over a referral (141:151) and upon receiving the news that the fibrillation has come back (317). The initial reaction was concern (320), but the physician was able to quickly and easily turn that around and inject some relief instead (321). The act-activity, like the former excerpt, is characterized by docility. The patient's statements of gratitude (142:152) and confidence in the physician's relaxing statement (322) are constituted by and constitute the physician's accommodating and concerned statements regarding the patient's need for a referral (141:145) and the soothing messages regarding the fibrillation (317:321). Compared to the patients in the first two excerpts, the patients in these two excerpts appear more amenable. The physicians seem quite abiding towards the patients and the excerpts point to consultations that are characterized by harmony between the two parties involved. The communicative constructions of the patients as amenable are enhanced by the constructions of the physicians as acknowledging.

Table 5. Excerpt 4

Line	Speaker	Utterance
A141	P2*	[...] We can see and check on them. Sure you can take them on Thursday when you come to the cardiac reception.
A142	NS2**	Yes it'll be great if I can do that.
A143	P2	Yes, and so.
A144	NS2	It's this Thursday?
A145	P2	Exactly, and we can ask that they give you a referral for that. I will see if I get this one out.
B150	NS2	But it's so hopeless when you're sitting and watching TV. I sit and watch an hour or two, then I sleep.
B151	P2	Yes exactly, but it may actually be that the metabolism is not completely on top, so I think you definitely should check that out, and if it's something that does not really work then I will simply get in contact with you.
B152	NS2	Yes, how lovely, so then you will write a referral to the lab then?
C317	P2	Relax, now. You're fibrillation has probably come back, I think it looks like.
C318	NS2	It has?
C319	P2	Yes.
C320	NS2	That's not good.
C321	P2	Well, though, it's not such a big deal, really, if you don't feel it, and that's the most important thing.
C322	NS2	Oh, yes, it is.

* P2 (physician 2)

** NS2 (Native Swedish speaking patient 2)

Social practice – Implications of the reciprocal constructions

This discourse dimension represents the summary of the consultations. It is comprised of conclusions and decisions made in the consultations. The way the patients presented themselves in the text dimension and the way the physicians related to them in the discourse practice dimension form the basis of how this dimension is understood. Two dichotomous discourses were identified: the preservative discourse and the monitoring discourse. In the consultations with the non-native Swedish speaking patients, the preservative discourse was drawn upon 12 times, the same number as in the consultations with the native Swedish speaking patients. The monitoring discourse was drawn upon 6 times in the consultations with the non-native Swedish speaking patients but 41 times in the consultations with the native Swedish speaking patients. Thus, the summaries, conclusions and decisions made in the consultations differed between the two patient groups.

The preservative discourse

This discourse represents the summaries, conclusions and decisions made in the consultations with the non-native Swedish speaking patients. The present dis-

course arises as the result of patients, in the participating patient discourse, primarily presenting themselves as somewhat demanding, and of physicians, in the argumentative discourse, contradicting the patients. In the excerpt below (Table 6), the patient and the physician together come to the conclusion that surgery is not desirable, even though the patient does not exceed the age limit and has sufficiently good health to withstand surgery.

Table 6. Excerpt 5

Line	Speaker	Utterance
A57	P1*	So that's kind of why I'm talking to you about it. I've read that you have discussed this with [Dr. X] and a little bit about various things. Then there is also the aorta to think about.
A58	NNS1**	Yes.
A59	P1	The widening up there, you're up in a measurement where as a rule we usually recommend action.
B78	NNS1	I asked (Dr. X) what the surgery involved. And he said it's rather lengthy and complicated, you're shut down, linked to lung-heart machine...
B79	P1	Heart-lung machine, yes...
B80	NNS1	And then you can get (laughs), something wrong in the brain, so I said no thanks! More problems, I don't want.
B81	P1	No, well, the risks are small, but I mean, naturally, there are always risks with surgery, as you know. So that, yes, that comes with the territory. Now, let's see, Levaxin 0.05?
C94	NNS1	Actually, my heart is not so bad considering my weight. I weigh 93 kilos – it can't be a very bad heart.
C95	P1	No, your heart isn't bad. I don't think so...Do you really need Digoxin?
D155	NNS1	But I'm almost 80, or 75 – I just turned 76, and there's no large margin if I were to have surgery.
D156	P1	No, well, I think the thing with prevention, somewhere around 80, that's where it goes, the limit. One can see a little bit what the average life expectancy is, and should you really do preventive stuff beyond that? When you start getting a little over 80? It seems a little doubtful [...].
D157	NNS1	Yes, I know. And I'm glad about that. But just for my part, this case, well...
D158	P1	Mm, no, I'm totally with you!
D159	NNS1	Are you with me?

* P1 (physician 1)

** NNS1 (Non-Native Swedish speaking patient 1)

The sequentiality and joint construction are manifested by the physician's first emphasizing that the patient ought to have surgery due to a widening of the aorta (59). The patient had received information about the operation previously and experienced that as rather deterring and therefore opposes the surgery (78:80). The physician then confirms some of the risks (79:81). Thereafter, the patient's condition for managing the surgery is established by both parties as fairly good (94:95), but then age is considered (155), and even though the pa-

tient's age is under the age-limit for when preventive measures are justifiable according to the physician (156), ultimately they both stand reluctant towards any intervention (156:157:158). The act-activity is characterized by conservation. The patient's cautious statements about the aorta operation (78:80:155:157) are constituted by and constitute the physician's similarly cautious statements about the operation (81) and about whether an operation is justified given the patient's relatively advanced age (156).

In the following excerpt (Table 7), the patient together with his attendant and the physician finally reach something like an agreement regarding an avoidance of cardioversion.

Table 7. Excerpt 6

Line	Speaker	Utterance
A166	P2*	No, it didn't go there, but it goes here, actually. 80 it says. That's really good. Have you done anything like a long-term ECG recording sometime?
A167	NNS2**	No, not what I, what I, I did a couple of times (inaudible).
A168	P2	Yes.
A169	NNS2	And then one (inaudible) here also.
A170	P2	Exactly, because now you see it's 86, and that's a little so-so, so then we should really see, because this is just single measurement he is taking now, we should see how you are now in your everyday life.
A171	NNS2A***	It's strange that the ultrasound shows 110.
A172	P2	But it may be just, but it may be due to stress. It may be just what you were doing right then.
B253	P2	But as it stands now, I do not think you need to do it.
B254	NNS2A	Get a new cardioversion, either, because?
B255	P2	No.
B256	NNS2A	Because of this with the left atrium?
B257	P2	We know that it'll not keep the sinus rhythm for long no matter what we do. If one is quite symptom free regarding fibrillation, then it's better not to mess with it because then it'll often be worse because then you're subjected to – although it's quite safe, everything we do still has risks – so it's better to keep it cool, because we know when we handle it well with Waran in your case and try to make sure you still have a good rate and check that it's always in a range such that you feel good, then we've pretty much optimized things. [...] The increased risk of clotting is there, of course, no matter what. It's not such a big deal.
B258	NNS2A	Is it the wear on the heart that is supposed to be worse if a person has fibrillation?
B259	P2	Yes, it's rather if it goes fast, not the fibrillation in itself wearing so much on the heart, rather it's the frequency. Then again, no one really knows the optimum frequency, but it seems, empirically speaking, like fibrillation that's somewhere between 70 and 90 at rest and maybe not upwards of more than 120 during effort is often very good.

* P2 (physician 2)

** NNS2 (Non-Native Swedish speaking patient 2)

*** NNS2A (Non-Native Swedish speaking patient 2 attendant)

The sequentiality and the joint construction are manifested by the physician's initially expressing enthusiasm over what the ECG showed (166). Then

the numbers increased, and the enthusiasm of both the physician (170) and the patient/accompanying attendant (171) decreased, even though the physician plays it down as due to stress (172). The physician maintains a wait-and-see approach and argues against giving the patient a cardioversion (253), which the patient/accompanying attendant questions (254). The physician retains the standpoint, even though the increased number of the ECG was within a range that the physician later stated to be troublesome (259). Due to the absence of any further argument, the patient and his attendant grant their approval to this approach. The act-activity, in resemblance to the former excerpt, is characterized by conservation. The patient's/accompanying attendant's initial questioning of the ultrasound numbers (171), wondering about the physician's standpoint on cardioversion (254), and finally, the conversion and internalization of the physician's position (256:258) are constituted by and constitute the physician's either positive (166) or defusing (170:172) statements regarding the patient's health status and the physician's non-advocating of the cardioversion (253:257:259). These two excerpts show how the preservative discourse is expressed by the non-native Swedish speaking patients and the physicians when uniting in a resemblance of consensus at the end. In excerpt 5, it is the physician who agrees to the patient's wishes to not have surgery, whereas in excerpt 6, it is the other way around as the patient and the attendant give tacit approval to the physician's proposal to avoid cardioversion. The discourse reflects assumptions that the non-native Swedish speaking patients need no further or specialized care. This is reinforced by the communicative construction of the two involved parties as each other's opposites when it comes to standpoints.

The monitoring discourse

This discourse consists of summaries, conclusions and decisions made in the consultations with the native Swedish speaking patients. The monitoring discourse arises as a result of the patients, in the amenable patient discourse, presenting themselves as complacent and amenable, and the physicians, in the acknowledgement discourse, meeting these patients with an equally amenable attitude. In the excerpt below (Table 8), the patient and the physician together conclude that the former is in need of future monitoring.

The sequentiality and the joint construction are manifested by the patient initially complaining about fatigue (22), which the physician believes is due to fibrillation (23). The patient has not had such bad experience with fibrillation that a cardioversion has been requested (24). Despite this, the physician suggests a change of medicine to a more effective one (49), which the patient agrees to (92) after asking some concerned questions (50). In contrast to the excerpts in the preservative discourse, the act-activity is characterized by monitoring and concern. The patient's complaints about fatigue and fear (22) and the acceptance of a new medicine constitute and are constituted by the physician's initial relaxing statement on AF (23), subsequent recommendation of a new medicine (49:51:91), deliverance of a referral to see another physician regarding the fatigue (85), and a message that the patient can call should anything come up (95).

Table 8. Excerpt 7

Line	Speaker	Utterance
A22	NS3*	Today was tough again, especially if you go and carry something because it's a little uphill up to my garage, so it might take two to three minutes to go that route. But I usually get to rest. I can't walk that whole stretch, and that's what's so hard. Partly you get so scared when you're about to go, and then you don't manage it...
A23	P4**	Yes, it's probably the atrial fibrillation that is the reason you feel like this. And you don't have to be afraid about the atrial fibrillation itself, but you should have good clot preventing treatment, and right now you have Trombyl. One can imagine that you have had cardioversion at some point where you...
A24	NS3	I've never needed it. When the heart beats fast, it has turned around within a day.
A25	P4	Have you had Waran at some point?
A26	NS3	No, I haven't.
B49	P4	When you have it it's good to treat it with Waran instead of Trombyl. Waran is good for preventing clots so that you don't get clots from the atrial fibrillation, that's really what is most serious. That's the biggest risk with atrial fibrillation - stroke. Perhaps you would be better served with Waran, that's, if you don't have anything against it. You can be given Waran instead of Trombyl. Then you have to check it regularly. In the beginning it's once a week and then maybe once a month [...].
B50	NS3	Mom had it a while. You have to be a little more cautious with it for bleeding and things like that I guess.
B51	P4	Yes, one bleeds more easily, and that's kind of the point with it. That's something that we could consider, that I write a referral to the health center or medical clinic in XXX, where they can put you on Waran.
C85	P4	Yes, yes, hm... I'll try to help you feel better. I'll write to the arrhythmologists and describe the problem and ask them to consider pulmonary vein ablation.
D91	P4	Hm, yes, but shall we say that we start just with this change, that I write about Waran to the health center?
D92	NS3	Yes.
D93	P4	And see you next week. Call me if there's anything.

* NS3 (Native Swedish speaking patient 3)

** P4 (physician 4)

In the following excerpt (Table 9), the patient and the physician also conclude that further treatment is desirable.

The sequentiality and the joint construction are manifested by the patient initially talking about symptoms of dizziness (76), which the physician links to swings in and/or low blood-pressure (77). The patient then describes a previous episode when the dizziness almost led to fainting (78). Towards the end of the consultation, the physician encourages the patient to leave blood samples before leaving the reception (208), announces availability to the patient should a number of symptoms appear (208) and shortens the waiting time for the next consultation (210). The act-activity is characterized by monitoring and concern. The patient's complaints of present (76) and previous experiences of dizziness (78)

constitute and are constituted by the physician's caring treatment manifested through concerned questions (75:77), ordering of blood samples, telling the patient to get in touch if the symptoms of dizziness do not disappear (208), and advancing the next consultation (210). The two excerpts exemplify how the monitoring discourse is drawn upon by the native Swedish speaking patients and the physicians. The discourse is characterized by an explicit attentive setting compared to the discourse available to the non-native Swedish speaking patients and the path to consensus also differs. In the two excerpts above, the consensus is being met through the patients' accommodation of the physicians' proposals. Unlike the discourse available to the non-native Swedish speaking patients, this discourse expresses assumptions that the native Swedish speaking patients are in need of further and/or specialized care. This is reinforced by the communicative construction of the two involved parties as each other's counterparts.

Table 9. Excerpt 8

Line	Speaker	Utterance
A75	P3*	[...] Now, during the past year, have you experienced any increase in dizziness? You said that you felt a little dizzy.
A76	NS4**	Dizziness, yes. When the blood pressure went down so much, I thought that could that be it.
A77	P3	It's clear that now the blood pressure is at that level, but it's a single measurement, and if you're treated for blood pressure and also a little more when you are older, it may be that the blood pressure swings a little so when you rise up and make sudden movements sometimes you have high blood pressure and sometimes perhaps even a bit too low, but you haven't felt like you were going to faint or fall over, or so?
A78	NS4	Yes, when I had surgery, when I was supposed to go to the physiotherapist and when I got there, I told someone, oh dear! When I see, I see the floor so close to me, I have to lie down somewhere.
B208	P3	Don't leave the reception without telling them to take blood samples, and I'll announce it at the reception, and you continue the rest of this medicine, but if you should feel more of the dizziness and discomfort, or God forbid palpitations or something, then you must call me so we can discuss. But we are going to try to reduce the dose even of Tamofor, actually.
B209	NS4	I see.
B210	P3	I'll book you preliminarily in about six or nine months so we'll see a little earlier just because – about function – to see that the medications that help you are not in any way threatening to upset other functions.

Table 9. Excerpt 8

* P3 (physician 3)

** NS4 (Native Swedish speaking patient 4)

Discussion

The paradoxical result of this study is that while non-native Swedish speaking patients communicated in a way that is in alignment with patient-centered care, this did not pay off in the treatment they received. The non-native Swedish speaking are well-informed, engaged in their diagnoses and they discuss and question their treatments. They are active and seem to embrace the patient role

advocated through patient-centered care. Theoretically, this should enhance their possibilities for experiencing desirable treatment. The rights of the patient are heavily emphasized today (The Office of the High Commissioner for Human Rights, 1993) and affect not only access to care but also interactive elements, such as consultations (Committee on Quality of Health Care in America, 2001; The National Board of Health and Welfare, 2009). The patient perspective is to be respected and taken into account, and patient-centered care is a key component of the implementation of this policy. However, these rights may also be considered as demands. The patient's involvement may not always be wanted, from the patient's perspective. Patients have responsibilities, for instance, towards the health care workers – to ask questions, make decisions about advanced directives, complain if their rights are violated, and assist in their own care (Miracle, 2011).

Drawing upon this notion of participation – as the non-native Swedish speaking patients did – ought to have meant that the patients were entitled to the benefits contained in patient-centered care. The non-native Swedish speaking patients showed signs of exercising their rights/obligations to participate in the consultations. The question is: What did they get out of it? Falkum and Förde (2001) studied physicians' attitudes towards patient involvement in decision-making. An overwhelming majority (80 percent) of participating physicians (6652 in total) were in favor of patient involvement in decision-making. Simultaneously, half of them believed that their ability to make decisions far exceeded the patient's. The discourse of participation, involvement and decision-making thus tends to become a discourse of non-existing choices (Fotaki, 2011). As it turned out, their involvement did not lead to their expressed wishes being respected. There is no such guarantee in any consultation; however, when compared to the consultations with the native Swedish speaking patients – who had no more apparent medical reason to have their wishes met, yet still did – the participation and involvement of the non-native Swedish speaking patients did not seem to increase their chances of being accommodated – quite the contrary. Whereas the communication in the discourses available to the native Swedish speaking patients is characterized by some sort of aim for consensus between the patient and the physician, the communication in the discourses available to the non-native Swedish speaking patients is characterized by more friction. Previous research has shown that immigrant patients are subjected to substandard communication in terms of them being less involved (Abrums, 2004) and more exposed to verbal dominance (Cooper et al., 2012; Johnson et al., 2004; Street et al., 2007). In the present case, a prerequisite for the contradictory communication is verbal involvement, a kind of patient participation, and there are no signs of any explicit exclusion of patient involvement in the consultations. Thus, the verbal dominance occurs after the involvement takes place: it is qualitative dominance rather than quantitative, dominance through content rather than by number or length of statements. What appears to be problematic in this case is that the act-activity interdependence is made up of a co-constitution of contradictory statements delivered by the patients as well as the physicians; that is, the contra-

dictions tend to lead to further contradictions. There seems to be a lack of connection in these discourses in the sense that the communication resembles parallel monologues in a dialogical practice. The joint construction consisted primarily of individual meaning-making. Consequently, the dialogue could be considered to be mono-perspectivised (Linell, 2009), with the two parties' holding on to their opinions, without being influenced by the other's previous statements. The connection consists of coherence with, or sequentiality to, each speaker's own earlier statements, rather than to the other party's statements.

This study contributes with a complex picture in the sense that patients' participation in the communicative construction is included and normative ideas of patient-centered care are discussed from the perspectives of both the patients and the physicians. The study has highlighted the communicative differences among the discourses available to non-native versus native Swedish speaking patients in consultations with physicians in order to increase the understanding of patient-centered care and its different manifestations. Using Fairclough's (1995) conceptualization of discourse and Linell's (2009) approach on dialogue and communication enabled us to first dissociate the content in the consultations on the basis of the origins and the contextualizations of the statements, and thereafter reconcile these statements in order to capture its interactivity. The dissociation illustrated the, in patient-centered care involved parts, different statements, and thereby their respective involvement in the patient-centered care. The reconciliation of the statements visualized how this involvement is co-constituted by the other parts involvement. In other words, Fairclough's conceptualization delimited, organized and structured the context, which had relational content ascribed to it through Linell's dialogic concepts.

Conclusions

This study illustrates how the consultations with the non-native Swedish speaking patients differed from the consultations with the native Swedish speaking patients. As mentioned, health care has difficulty living up to the key principle of equality. Immigrant patients receive inferior care compared to native patients (Abrums, 2004; Diaz, 2009; Johnson et al., 2004; Szczepura et al., 2005). Although the clinical results fall outside the scope of this study, the communication may very well have clinical effects, as Diaz (2009) points out, depending on its implementation. The communicative construction of the patients can be understood, from a social constructionist perspective, as the patients' and the physicians' reciprocally ascribing the other party, as well as themselves (self-ascription), certain attributes during the consultations. The different attributes ascribed by both parties in the non-native Swedish speaking patient consultations lack compatibility, whereas a higher degree of compatibility was observed in the consultations with the native Swedish speaking patients. The communicative constructions of the non-native Swedish speaking patients as participating and the physicians as argumentative, seen from the perspective of the preservative discourse, together suggest that socially defined differences – based on physical

characteristics, culture, and historical domination and oppression, and justified by entrenched beliefs – do have bearing on how communication unfolds in consultations. Even though the non-native Swedish speaking patients showed signs of being “model patients” in terms of being involved and active in the consultations, this involvement may have been part of the reason for the dialogical tension between them and the physicians.

The non-native Swedish speaking patients acted differently than the native Swedish speaking patients: They presented themselves as participating in that they expressed demands and signaled various forms of dissatisfaction. The native Swedish speaking patients, on the other hand, presented themselves as amendable, in terms of docility and accommodation towards the physician. Regarding the role of the physicians, their responses differed between the two patient groups. Towards the non-native Swedish speaking patients, the physicians acted argumentatively, with contradictions and dismissals. Towards the native Swedish speaking patients, however, their responses were acknowledging, with consents and confirmations. When decisions, conclusions and summaries were jointly made, the result in the consultations with the non-native Swedish speaking patients was preservation of the status quo through restraint, while the corresponding result with the native Swedish speaking patients was monitoring of their health status through attentiveness and care. In this respect, this study confirms the previous research done on health care inequalities from a multicultural perspective. In addition, this study discusses patient participation through the concept of patient-centered care. The non-native Swedish speaking patients are examples of patients who act in accordance with the concept. The fact that these patients’ active participation primarily results in dismissive and argumentative responses from the physicians raises the question of whether the notion of patient participation is to be understood as a concept with practical bearing or merely as a populist, theoretical buzzword.

To reply to Braveman and Gruskin (2003), as well as Ahlberg and Krantz (2006), the language itself and the manner in which it is used by both parties in the consultations, appears to be stereotyped. Stereotypes carried by language influence the communication, which in turn contributes to create different conditions for consultations with native versus non-native speakers.

Implications

The ideal patient seems to be a patient who either surrenders responsibility to the physician or, when taking responsibility and participating in the consultation, does so in a docile manner. This raises the question of whether patient docility is a prerequisite for successful patient involvement and patient-centeredness. So far, the discourse of involvement and patient-centered care has focused on the patients’ perspective, which is not very remarkable; however, in consultative settings, another party is involved, a party who, unlike the patient, does not get more influence, but rather, must give some up. Further research on the conditions for patient involvement would be welcomed. In order to provide a multi-

perspective consultative setting, the perspective of the health care workers ought to be considered in order for them to get any proper condition for accommodating the patients' perspective.

The findings lead to questions of whether the notion of participation is practically feasible, if it is a discourse that is available to patients or, rather, just a theoretical and administrative idea. These questions call for further examination in future research.

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Notes

¹ A great selection of similar concepts (for instance person-centered care, client-centered care and individualized care) has been used, sometimes presented as synonyms to patient-centered care, sometimes as being originated from different fields and thereby having somewhat different focus. We understand the different concepts as synonyms in accordance with Edvardsson and Innes (2010) in the terms that the concepts highlights the person at the center of the care rather than the condition/illness. We choose to use the most commonly used concept – patient-centered care – as indicated by the number of published articles.

² The material was originally collected for another study (Siouta et al., 2012). The original material consisted of 24 consultations with nurses and physicians, wherein strategic selection (Fridlund, 1998) was applied on health care workers (based on variation regarding gender, age and clinical experience of cardiology) and patients (Ford, Schofield, & Hope, 2002) (based on sex, age, education, type of AF, time since diagnosis, type of planned visit, treatment regimen and ability to communicate in Swedish).