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# Health Encounters with Minority Patients – Changing Perspectives from Tolerance and Intercultural Communication to Empowerment and Shared Decision-Making

*Ragnhild Ihle*
*Department of Social Education and Social Work*
*Bergen University College, Norway*
*rih@hib.no*

*Tobba Therkildsen Sudmann*
*Department of Social Education and Social Work*
*Bergen University College, Norway*
*tsu@hib.no*

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## Abstract

*During recent decades there has been an increasing claim for patient participation and shared decision-making in health services across the Western world. Focus on participation recasts the relationship between healthcare providers and their patients. Professionals are compelled to acquaint themselves with new worldviews, new ways of understanding illness and disease, and to communicate with patients with language, religion and cultural backgrounds increasingly different from their own.*

*Contested concepts such as communication, tolerance, participation and shared decision-making emerge, as do claims about non-participation, oppressive practice and muting of patients. In this article we look into how the paternalistic tenets of intercultural communication, tolerance and the culture of medicine intersect in such ways that empowerment and shared decision-making in health can be constrained. Modern day health concerns such as lifelong disabilities or chronic illness have multiple faces, and there is no one agreed-upon approach to assessment, treatment or non-treatment. Patients and providers have to engage in communication to detect enablers and constraints, bodily and socially. If communication is envisioned as a one-way delivery of knowledge or prescriptions, or a difference in culture is magnified to a degree that other characteristics fade away, the patient risks oppression, muting, and poor healthcare.*

*We argue in favour of appropriating a critical perspective on interaction in healthcare and intercultural communication, and in favour for interpreting face-to-face interaction as situated social practice. A situated social practice compels those present to communicate to create an agreed-upon situational definition, and to enter into a recuperative dialogue where patients too may exercise agency and present themselves as empowered.*

## Introduction

During recent decades there has been an increasing claim for patient participation and shared decision-making in health services in Norway, as well as in many other European countries. The increased focus on participation brings forward new understandings of the encounters between professionals and patients. It also challenges professionals to acquaint themselves with new worldviews, new ways of understanding illness and disease, and to communicate with patients from diverse backgrounds along many different dimensions (Malterud, Candib, & Code, 2004; Thesen, 2005). Communication, tolerance, participation and shared decision-making are contested concepts, and some of the practices these concepts denote might be non-participatory or even oppressive. These practices can even influence patients in such a way that they actually become muted in the communication.

Below, we will question how the underlying premises in intercultural communication, tolerance and the culture of medicine may intersect in such ways that empowerment and shared decision-making in health can be constrained.

Charles et al. (1997) critiqued three of the most prominent models for decision-making in health: the paternalistic model, the physician-as-agent model, and the informed patient model. All three are one-sided: either the physician decides by himself (sic) due to his professional or agent position and the patient complies, or the informed patient makes all the decisions and the physician complies. Charles et al.'s discussion of key characteristics of health encounters renders these models inadequate for current challenges. Apart from acute and emergency related care, health challenges concern how to live with non-communicable diseases (NCDs) or chronic illness. Charles et al. (1997:681) suggest that for shared decision-making in health to be possible, four characteristics must be present:

(1) that at least two participants—physician and patient be involved

(2) that both parties share information

(3) that both parties take steps to build a consensus about the preferred treatment, and

(4) that an agreement is reached on the treatment to implement

Today, WHO states that NCDs are the leading cause of deaths and disability in the world. NCDs seldom prompt immediate medical decisions, but often have a wider impact on the well-being and life situation of the patients. Shared decision-making provides a model for assessing the advantages and disadvantages of different treatment plans. Deegan and Drake (2006) asserts that new models are needed when dealing with long-term health challenges:

> In the shared decision-making paradigm, the language of medical authority, compliance with therapy and coercive treatments disappears in favor of terms and concepts like education, working alliance, individual experience, informed choice, collaborative experiments and self management of illness (Deegan & Drake, 2006: 1638).

The concept of sharing as opposite to one-directional is brought forward in DeTurk's (2010) study on intergroup dialogue, which has a ring to Charles et al.'s (1997) characteristics of shared decision-making in health. DeTurk states that sharing happens in the mutual presence of others, in hermeneutic listening, and through taking the perspective of others. A central element of sharing was the virtue of *non-judgmentalness.* To be non-judgmental was part of the sharing experience, as a marker of *moral autonomy*. Implied in this autonomy was a concept of tolerance, which allows people to share without being morally judged. However, when differences between people are perceived as obstacles to interaction, tolerance and non-judgmentalness might turn out to be uneasy bedfellows (DeTurk, 2010).

## Understanding the other – the problem of tolerance

Political scientist Wendy Brown has written a thought-provoking volume on tolerance, entitled *The Regulation of Aversion. Tolerance in the Age of Identity and Empire (Brown, 2009)*. Tolerance is typically conceived as an individual virtue, raised from and respecting the value of moral autonomy, and acting as a sharp rein on the impulse against being superior to the belief and actions of others.

> Like patience, tolerance is necessitated by something one would prefer did not exist. It involves managing the presence of the undesirable, the tasteless, the faulty – even the revolting, repugnant or vile. In this activity of management, tolerance does not offer resolution or transcendence, but only a strategy for coping (Brown, 2009: 25).

She points at power and authority as presuppositions of tolerance as a moral and political value. To be in the position to tolerate means a posture of indulgence that endures, permits or licenses.

Robinson, Witenberg and Sanson (2001) have studied how tolerance as an individual virtue can be learned, and how belonging to different ethnic or cultural groups impacts on tolerance. They describe four levels of tolerance:

1) Individual endurance – to put up with the differences

2) To be fair and objective – ignoring the relevance of difference

3) Conscious rejection of prejudice

4) Full acceptance – celebration of difference

The four levels of tolerance imply that the upper level is the supreme level, and that socialization of tolerance is possible. However, Brown's (2009) argument is that such calls for tolerance produce objects of tolerance, and that learning tolerance is actually learning to tolerate reiterated differences. The concept of tolerance is either concerned with an individual ethic related to individualized objects, or it is concerned with a political discourse where objects are positioned in designated modalities of, for instance, diversity, identity, and justice. According to Brown, tolerance does not simply mean withholding your reactions according to likes or dislikes, but to act on social, political, and religious and cultural norms. These norms are associated with certain practices that licenses and regulate perceived difference. When tolerance is de-politized, respect and justice are substituted with personal sensitivity, historical induced suffering is reduced to '*difference*', and the field of political battle and political transformation is replaced with an agenda of behavioural, attitudinal practices (ibid.:16).

Brown acknowledges the value of tolerance as displayed and enacted at an individual level, but is at pains to demonstrate that:

> (…) calls for tolerance, the invocation for tolerance, and the attempt to instantiate tolerance are all signs of identity production and identity management in the context of orders of stratification or marginalization in which the production, the management, and the context themselves are disavowed (Brown, 2009:14).

Tolerance as a political discourse is the production of stereotypes and tropes of the 'others' – the objects of 'our' tolerance that deviate from 'us' by gender, race, ethnicity, religion, education, culture, and so forth.

Brown further argues that when difference itself is the focus; tolerance conflates and covers the different subject positions that are produced and reinforced by 'us' who tolerate 'them'. Tolerance as a discourse or trope is a product of superiority, which is directed towards someone inferior, categorized as being of lesser value, deviate, stigmatized, marginalized and so forth. The concept serves to depoliticize challenges facing people in marginal positions (ibid.).

When tolerance is called for in health encounters between minority patients and (majority) professionals, the aim is to encourage professionals to create health promoting encounters with their patients through shared decision-making. However, the political discourse on tolerance will serve as an interpretive backdrop for all concerned. Appropriating Brown's perspectives on these encounters creates an urge to unpack what participation in health encounters entails.

## Participation in health encounters

In Norway, several measures during recent years have facilitated increased user involvement in health services, both in the new Act on Health and Social Services,[1] and the Patient Rights Acts. The Patient Rights Act §3-1 states that information should be adapted to the individual's ability to give and receive information. In §3-5 this is elaborated further where it is stated that: '*Information shall be adapted to the qualifications of the individual recipient, such as age, maturity, experience and cultural and linguistic background. The information shall be provided in a considerate manner*'. [2]

This raises an important question: How does providing and receiving information, even if the information is adapted to person, place and situation, relate to participation or shared decision-making? The concept of participation is contested, as is intercultural communication. In Arnstein's (1969) seminal article on citizen participation in political decision-making, there are seven rungs reaching from the bottom manipulation to the seventh rung exercising citizenship. On her ladder of participation, information-exchange is the third lowest rung, over manipulation and therapy. The two lowest rungs are considered non-participation, the middle rungs are tokenism, and the two top rungs are worthy of being called citizen power (Arnstein, 1969). Information is on the borders between non-participation and tokenism.

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[1] www.lovdata.no/all/nl-20110624-030.html

[2] www.ub.uio.no/ujur/ulovdata/lov-19990702-063-eng.pdf

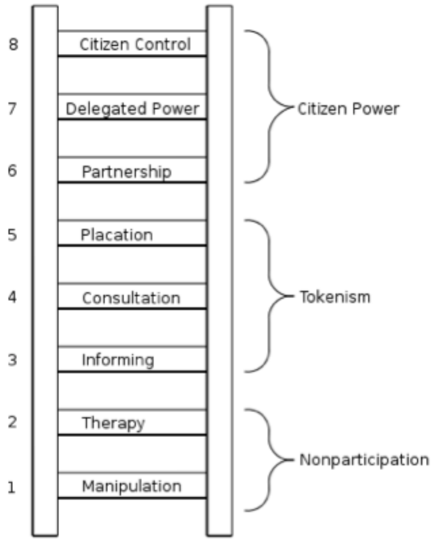

Figure 1. Ladder of participation (Arnstein, 1969)

In health communication, if conversation goes awry, an intended shared decision-making might result in non-participation or tokenism. The lower rungs can also be referred to as compliance, or obedience to medical authority, which makes it difficult to address the complexity of decisions involved in medication and recovery.

Research on client participation in public services often distinguishes between two conceptual models or approaches (Beresford, 2002). One originates from market economy, where services are perceived as products, and clients are seen as consumers of these products. Assumingly this is an approach that fits the emergence of New Public Management in the public sector. The other approach originates more from a humanistic way of thinking as a reaction to paternalism and expert orientation to services, demanding a more democratic public sector altogether. This has an emphasis on the involvement of users directly in the decision-making processes and the need for democratization at the local level (ibid.).

Many client groups have, over the years, criticized welfare services and demanded active changes and better user involvement (Rutter, Manley, Weaver, Crawford, & Fulop, 2004). The claim for more user involvement has been connected to rights as citizens of a given society. Some researchers point out that user involvement is difficult to measure and monitor, but it seems like involvement mainly takes place in consultation and information, rather than ‘powersharing’ (Arnstein, 1969; Campbell, 2005; Rutter et al., 2004; Tait & Lester, 2005). Unpacking participation constructs new roles for agentic clients or patients: from users and choosers to makers and shapers (Cornwall, 2008; Cornwall & Gaventa, 2000).

Edwards, Davies, and Edwards (2009) claim that level of health literacy – the skills of the individual to access, receive and process health information – affects communication and information exchange between patient and professional. In turn, this means that knowledge and information made available to patients will be absorbed and acted upon very differently according to their health literacy. Their review shows that language barriers between patients with a minority background and professionals with a majority background in health services pose a risk of mistakes and unfortunate situations during treatment. They also reveal that many US immigrants have limited knowledge of health services and show low health literacy (Edwards, Davies, & Edwards, 2009).

A report on minority health in Norway describes how challenges related to language and communication are often understood as differences in culture and religion (Spilker, Indseth, & Aambø, 2009:40). This report suggests emphasizing challenges in communication rather than cultural differences, and that this will increase the probability of a more prosperous encounter between the minority patient and healthcare providers. A National Strategy Plan 2013-2017 from the Ministry of Health and Care in Norway concerning immigrants' health, expresses the overall aim of social inclusion, and connects this to equality in health services. Equality in health services here means equal worth, not depending on diagnosis, background, personal economy, gender, country of origin and individual life situation. The report focuses upon special health challenges with specific immigrant groups, and on challenges in the encounter between professionals and clients that are construed as being related to culture and language (Helse og omsorgsdepartementet, 2013-2017).[3] In a study on general practitioners' (GP's) experience with migrant patients, the GPs expressed that migrants seemed helpless in encounters with public health services due to language difficulties, differences in expectations, and a systematic failure to co-ordinate care (Goth, Berg, & Akman, 2010).

In Adebe's review of public health challenges and immigrants in Norway it is also stated that research into migration and health may contribute to migrants' vulnerable position, and that one may risk that '*migrants stand out as anomalies in a society that is otherwise perceived as holistic and stable* (Adebe, 2010).[4] Migrant and minority-studies include socio-cultural dimensions, as well as language dimensions and an understanding of power relationships. Subsequently, these studies would benefit from a *multidimensional* sensitivity in their approaches. Some of these dimensions represent silent issues, or issues difficult to express, like '*experiences of fall in social status, social isolation, racism and discrimination, defeat in work or school, gender ambiguities, conflicting generational roles*' (Adebe, 2010). Issues even more concealed could be experiences of war, violence, rape, persecution and torture (ibid.). Adebe's study is a call for further enquiries into how minority patients and professionals enact the medical encounter.

## Health encounters as oppression and one-way communication?

Based on a study of community-dwelling psychiatric patients' experiences of being reclassified as the stigmatized 'other', Thesen stresses the processes of objectification these patients experience, and how they are reclassified from a human being to a psychiatric case (Thesen, 2001). The process of objectification carried great consequences for how the persons envisioned themselves (self-esteem) and how others envisioned them (public esteem). She asks for a reflection among doctors on power issues, and shows that medical practice is experienced at times as oppression by patients:

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[3] Likeverdige helse- og omsorgstjenester - god helse for alle. Nasjonal Strategi for innvandreres helse 2013-2017. www.regjeringen.no/pages/38431748/Likeverdige_tjenester.pdf

[4] www.migrasjonsforskning.no/site-no/04-Publikasjoner/.pdf

> Why did doctors like me take up the role of oppressor in medical encounters? Was it mainly due to personal shortcomings, or was the reason more structural? How could the oppressive practice be described? If I accepted that I sometimes acted as an oppressor on my patient, how could I change? And why had those power issues been predominantly invisible to me in the past? (Thesen, 2005:47).

Thesen states that oppression starts with objectifying the other person, and in that objectification the person's diversity is blurred and can lead to cultural stigmatizing. Patients from stigmatized groups are especially at risk of becoming *'the other'* when seeing the doctor. The stages of oppression are illustrated in the following model:

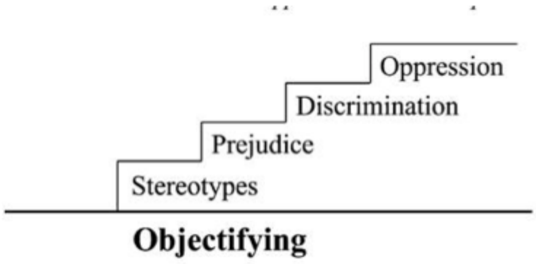

Figure 2. Staircase to oppression (Thesen, 2005:49)

Thesen's context for the oppression model is based on research and experience from primary healthcare. Interestingly, Dahl's model of cultural essentialism in intercultural communication resemble Thesen's model. Where Thesen's model is based on steps that lead to oppression, Dahl's model is cyclical in the sense that the elements in the process reinforce the understanding of cultural essentialism - preconceived fixed understandings of the other, based on some essential features of a given culture, most often a national culture. If communication starts with essentialism, these understandings are cognate to stereotypes: 'they are like this and like that', and stereotypes can lead to prejudices. This can eventually lead to *processes of othering*, and to *culturalizing* (Brown, 2004; Jensen, 2011), where the significance of culture is magnified so that other relevant aspects are considered irrelevant.

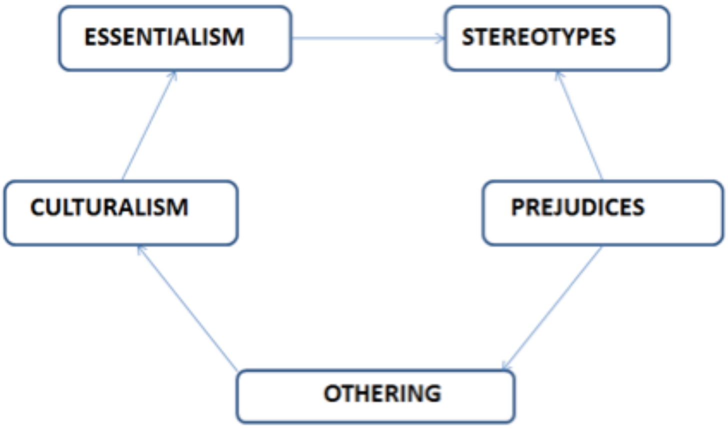

Figure 3. Model of essentialism (Dahl, Dybvig, & Keeping, 2013:72)

In both of these models the professional is seen as an expert and as an addresser of communication, and the professional sees the interlocutor as an object of communication and site for intervention. Historically, cultural *Others* have been targets for description and interpretations by outsiders (Jandt & Tanno, 2001). In intercultural communication the cultural other is *a stranger,* and in other situations the *cultural other* can be described as a representative for the exotic, for the native, or the untouched. The language of how *the other* is described can often be seen as a language of domination, described as a kind of *perceptual imperialism- the process of observing and interpreting information about cultural others through an underlying set of ideas based not so much on reality as on myth* (ibid.).

In much of the dominant language describing cultural others, they are not defined according to who they are, but who they are not (example: non-white, non-Norwegian, uneducated, unemployed, unhealthy and so forth). This negative labelling can result in a negative experience of *the self* for those concerned. Often this labelling can appear as culturizing or ethnifying, which serves to magnify the meaning of culture or ethnicity in defining a person. This way one constructs the cultural other as determined by their culture, in opposition to 'ourselves' who are constructed as just acting (naturally) in relation to cultural values (Gullestad, 2002; Jensen & Halkier, 2011). *Othering* can in this way be seen as an effect of cultural essentialism, where *the other* is reduced to being an object determined by a culture (Ytrehus, 2001). This could be conceptualized as *cultural determinism*, where culture becomes a dominant factor to explain human behaviour (Holliday, 2011). In our case, when discussing the intercultural encounter between healthcare providers and their patients, we see a kind of *double othering* where the patient may be construed as the *medical other* and *the cultural other* in the same situation.

If patient participation and shared decision-making is the aim of communication, patients are expected to be addressers, to be active subjects in creating a situated conversation (dialogue), presenting their ailments or concerns and preferences in their encounters with providers. To make space for patients' agency, we need to challenge our un-reflected construction of the patient-as-object or as a stranger. Rather, the patients' initiatives must be welcomed and appreciated, and the professionals must validate their position as subjects.

To be a patient or a client with a minority background who must often express themselves in a foreign language means facing categorization along a series of positions. Different categories based on identity markers such as age, gender, religion, and ethnicity may add to the asymmetry between the provider and receiver of healthcare, and increase the risk of oppression. The majority, or the groups at the top of social hierarchy, seems to determine to a great extent the communication system of the entire society (Ardener, 1978; DeTurk, 2010; Kramarae, 1981; Orbe, 1998). Over time, the structures of communication - based on the worldviews of the dominant group - are reinforced as the appropriate communicative system for both dominant and non-dominant group members (DeTurk, 2010). The medical culture has a stronghold on more than health, and enforces social hierarchies (Lupton, 2012). Orbe (1994) points out that the established communication structures render marginalized groups largely muted because their lived experiences are not represented in these dominant communication structures.

Relationships between professionals and clients also exist in specific institutional structures. Heritage points out that interaction between professionals and clients can be seen as institutional interaction, where asymmetrical relationships are one of the basic elements (Heritage, 2005). Valero-Garcés discusses the asymmetry of knowledge, both in the institutions where the interactions takes place, or the eventual medical knowledge in itself, where the client as an addressee does not know or fails to understand the line of inquiry or purposes behind the questions in the interaction (Valero-Garcés, 2002). In her study of immigrant users of health services in Spain, she found that when the client had limited resources to communicate, the professional tried to balance the asymmetries by using specific strategies or performing specific roles like a father in consultation with a child, or by lowering the linguistic level of his/her intervention, or by using a simpler language or even incorrect grammar (ibid.). The general societal expectations that guide the behaviour of doctors and patients has been identified by Parsons (1975), where he portrays a paternalistic relationship in which the doctors occupy the dominant position by virtue of their specialist knowledge and the patients merely cooperate along the doctor's guidelines. The doctor is dominant and acts as a 'parent' figure who decides what he or she believes to be in the patient's best interests. A paternalistic relationship traditionally characterized medical consultations and, in some situations, we acknowledge that patients derive considerable comfort from being able to rely on the doctors, and be relieved of burdens of worry and decision-making.

Whereas Parsons (1975) would focus on the relationship between patient and doctor as a role relationship, today we focus upon 'situated actors' with a 'positioned knowledge' (Bastalich, 2009; Jensen, 2011). Brown (2009) and Lupton (2012) are both inspired by and indebted to the French philosopher Michel Foucault. His concept of *biopower* emphasizes manifested language and practices in institutions as expressions of power, e.g., the relationship between professionals and their objects (persons) of interest. Asymmetrical relationships emerge as normalized institutional interaction where the professional is part of the institution's disciplinary forces. Professional knowledge and client knowledge have to be negotiated inside the context of the institutional setting, where the professional and the client represent different voices, as actors in a discourse (Lupton, 2012). The medical culture a priori favours the professional position, making it hard for patients to even discover the conditions for their participation in the health encounter.

Mishler (1984) distinguished between 'the voice of medicine' and 'the voice of the life world'. According to him, evaluations of doctors seem to reproduce the voice and the knowledge of medicine, while the patients speak from the life world. If this kind of interaction is seen through the lens of intercultural communication, the patients' expressions of their lifeworld - their illnesses, experiences, values, senses of self – risk being interpreted as a difference of culture. Culture, in this sense, is often seen as an obstacle for interaction and successful communication and will be interpreted as the addressee's (patient's) limited capacity to process the messages given from the professional (Gudykunst, 1984). In this lies a notion of incapability - that one person's description and the doctor's diagnosis both refer to the same domain of shared reality, where one party enjoys privileges over the other (Maynard, 1989).

Valero-Garcés (2002) asserts in her study of the encounters between professionals and immigrant patients that these are organized in such a way as to elicit descriptions and evaluations that works in different ways according to who produces them, or more exactly, according to the physicians' positions. When this is added to the cultural differences involved asymmetries might be accentuated, and the effort needed to break the communication breach is bigger (Valero-Garcés, 2002:491). This ties into what is described above, how hierarchies determine communication structures, and renders people partly silenced in communication with professionals (DeTurk, 2010; Orbe, 1998; Thesen, 2005).

## Shared decision-making and intercultural communication

Intercultural communication and patient-healthcare provider communication represent broad areas of research, but these two areas are rarely combined together (Ulrey & Amason, 2001).

While discussing the practice of shared decision-making, one can find another practice in medicine and in intercultural communication, more known as the '*the gaze*' towards 'the other' (Malterud et al., 2004). '*The gaze'* means the way one perceives the other is processed on the basis of preconceptions, such as understanding of the person's diagnosis or of the person's culture. Foucault describes how the medical gaze of the professional is taken to be the true source of medical knowledge, which has consistently been privileged over the voice of the patient (Foucault, 2002). In intercultural communication, one could say that there is a correspondent '*cultural gaze*' where the anthropologist or the cultural expert would claim to know and explain the individuals' action on the basis of the culture the person belongs to (Gudykunst & Kim, 1984).[5] This implies a notion of addressing people based on some given preconceptions.

> As a professional I know about you on the basis of your diagnosis, and as an expert of anthropology I will assume certain attitudes and styles of behaviour if you come from a given culture. Basically this is seen as a fundamental professional knowledge in order to interpret and predict behaviour (Gudykunst & Kim, 1984:26).

From a social constructionist point of view, it can also be seen as a positivistic, essentialist position defining persons into predefined categories, without considering that persons actively define and give meaning and actively take a stance as to whether they want to identify themselves with a given category or not (Burr, 2003). From an empowerment point of view, one should not only be treated as a number, or a representative of a social category (Askheim, 2012).

In intercultural communication the categorization has, to a large extent, been based upon the concept of culture, and culture has often been referred to as national culture. Otten and Geppert (2009) refer to Edward Hall and his basic idea of cultural determination:

> Hall's basic idea of cultural determination of human communication and behaviour, as well as the variant distribution of cultural values among nations and ethnic groups has set a conceptual benchmark and was then adopted in many other seminal empirical works (…).(Otten & Geppert, 2009:6)

Both in large quantitative cross-cultural studies (Hall, 1973; Hofstede, 1984) and in face-to-face interaction approaches (Collier & Thomas, 1988; Gudykunst & Kim, 1984; Porter & Samovar, 1994) the focus would be on culture, and how culture affects people's lives and interactions. In this lies a large discourse on culture, situated between the positivist paradigm and the constructivist paradigm (Jensen, 2003). Otten and Geppert (2009) defines a correspondent division in two opposite fundamentals of culture in interaction, where they label the traditional notion as '*being culture'*, whereas the second conceptual notion is characterized as '*doing culture*' (Bauman, 1999; Jensen, 2011; Otten & Geppert, 2009). *Being culture* refers to an essentialist perception of culture, where, through large surveys, one tries to establish general patterns most often about nations, people's behaviours, interactions, beliefs and so forth.[6]

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[5] The concept of the *gaze* has been exemplified as a spotlight illuminating '*the other*' in encounters between professionals and client. See Ihle, 2008.

[6] See Hofstede 1980: *Culture´s consequences*: *International differences in workrelated values*

When sharing knowledge of persons, national stereotypes are part of that knowledge, and these stereotypes are often used as explanations behind statements. Jensen refers to discussions about culture in the four last decades on whether culture is a concept, a structure, or a practice, and she also questions whether culture should be seen as one coherent cultural system, or many practices in everyday life (ibid.) *Culture as practice* reflects the '*doing culture*' perspective, and this in a way rejects pre-existing belongings and predefined cultural distinctions. Practice theory refers to the embodied and material derivate of cultural meaning (Otten & Geppert, 2009).

> Practices are the routines of individual actors inscribed in the way they use their bodies, in their habits, in their taken for granted sense of space, dress, food, and taste, in the social routines they know so well as to be able to improvise spontaneously without a second thought (…) Practices can also be trans-personal imbedded in the routines organizations use to process people and things, in the taken-for granted criteria that separate one category of people or event from another (Swidler, 2013:74).

The focus upon *culture as practice* suggests a paradigm shift towards a more hermeneutical, interpretive and constructive understanding of social phenomena, e.g., health encounters. Following this lead, mutual presence can be interpreted as different modes of participation and interaction, where the actor is construed as a performing agent who makes and manages a plurality of options within the diversity of co-cultures. Agency can be observed even in constraining and oppressive health encounters – e.g. by interpreting silence as communication and non-compliance as strength (Sudmann, 2009). Within this frame of reference, intercultural communication cannot be seen only in terms of language, but rather as social action.

## Communication as social action

The concept of the individual in the practice theory approach is related to Giddens' perspective of an actor, but it also focuses on individual agency (Jensen, 2011). The actors in communication situations are seen as active, reflective and interpretive interlocutors who are able to reflect and make individual decisions on how, for example, to handle cultural differences. To handle differences would, in a practice theoretical setting, involve all the actors and represent much more of a situational approach, where culture is the theme for negotiation, rather than a quality of individuals. To negotiate meaning is salient in any health encounter, and the interlocutors should try to agree upon a situational definition, and means and aims of the conversation. To discover actors' different rationalities, and the rationalities of the contexts are part of their mutual negotiations.

Handal and Lauvås, who have focused upon healthcare professionals' relationships with patients, have developed a taxonomy of rationality to understand approaches to encounters between healthcare professionals and patients (Handal & Lauvås, 2014).

| Goal-rationality | Communicative rationality | Critical rationality |
|---|---|---|
| Orientation towards results | Orientation towards understanding | Problematization |
| Instrumental action<br>-To master<br>-To effectuate<br>-To control | Meaningful action<br>-To interpret<br>-To establish a mutual understanding<br>-To establish common norms | Liberating action<br>-To analyse<br>-To assess critical conditions<br>-To establish own position |
| Which actions relevant to reach the goals? | What do the goals and actions mean for the different actors? | Why are goals and actions perceived in this way or that way? |

Model 1. Taxonomy of rationality (Handal & Lauvås, 2014:77, our translation)

These rationalities are part of the context of communication. First, personnel in a casualty ward have to acquiesce critical information about the patient such as heart rate, blood pressure or respiration, in order to start a life-saving action. Here, goal-rationality is necessary. In terms of intercultural communication, we will argue that intercultural communication and many of its theories has had a strong emphasis on goal-rationality with an orientation towards the technical aspects of communication and the expected outcomes connected to it (Rathje, 2007). The focus here would be on '*how-to-do*' and best practices (Jenssen, 1998:32). This goal-orientation ranges from economically oriented applications that emphasize efficiency to more academic or education-based perspectives that emphasize human development (Rathje, 2007; Ting-Toomey, 1988). Having intercultural competence is, in this perspective, seen as a means for more efficient interaction, meant to increase productivity in intercultural interactions. Thus, intercultural competence is seen as an instrument of success (Rathje, 2008).

Second, the current claim for shared decision-making in health and welfare services reflects a need for a communicative rationality, associated with negotiations of how the patients' life situation and wellbeing will be affected. These negotiations must capture the dynamic complexity of autonomous clients who have to navigate decisional conflicts in learning to manage disease and illness (Deegan & Drake, 2006). They have to capture how professionals have to bridge the empirical evidence of treatment with the unique concerns, values and life context of the individual client (ibid.:1636). A quest for a more communicative rationality puts communication into a hermeneutical framework - into the search for meaning, mutual understanding and negotiation of terms and values.

Third, the claim for client participation also demands a critical rationality;

> The critical rationality adds another dimension to the other two. While we in a goal-rationality context stress the importance of effective management, and in the communicative rationality focus on meaningful action based on a common understanding, we are in the critical-rationality context engaged in exploring why we understand and act as we do, what the underlying or implicit conditions are that makes us understand and act the way we do. Thus we are interested in revealing what we take for granted, 'what seems to be obvious,' and affects our actions (Handal & Lauvås, 2014:78, our translation).

Critical learning is one dimension of social interaction, and a key to empowerment as emancipatory practice. Critical learning is a hallmark of critical hermeneutics – to interpret the conditions, enablers and constraints for the situation at hand. Ledwith and Springett (2010) have created a multidimensional model of participatory practice, consisting of worldviews, social practice, empowerment, critical education and social justice, theory, biodiversity and democracy. The anthropology at heart states every human being as always already social and capable of interaction – in one way or another. Ledwith and Springett are indebted to the Brazilian pedagogue Paolo Freire (Freire, 1995), who has inspired marginalized and underprivileged people across the globe for decades. Freire shared his epistemological and ontological point of departure with sociologists such as Giddens and Goffman (Giddens, 1984; Goffman, 1972, 1983), and hermeneutical philosophers such as Gadamer (1996) in that understanding the other starts with curiosity and dialogue, and differences along all known and unknown dimensions are potential resources for interaction and social change. Brown's (2009) critique of the instrumental use of 'tolerance' finds harbour amongst these theories.

## Moving towards empowerment

Shared decision-making is a promising practice, where bilateral curiosity and learning have a ring to emancipatory versions of empowerment. The World Health Organization, WHO, states that empowerment is a process of growth and learning, and where health is concerned this growth and learning must be stimulated in the patients, their carers and the professionals. Empowerment is a much-used concept, currently used for different purposes, amongst them highly instrumental ones – where empowerment is just another word for governmentality or governance. The intersection of medical authority and ideology and instrumental versions of empowerment are cognate to the versions of tolerance criticized by Brown (2009) – where tolerance iterates differences. If versions of one-directional intercultural communication are added to the picture, minority patients risk facing triple disadvantages in health encounters.

The reasons for seeking contact with healthcare professionals are always bodily concerns (mental health manifests itself through the body), which are differently experienced, interpreted, lived and narrated due to individual and structural life conditions. There is an increasing awareness in the medical profession and other associated professions, that the patients/clients should participate in the processes around their own treatment, and be involved in shared decision-making concerning their own health. This is seen as a general improvement in healthcare, and we can also argue that increased participation brings more adherence to the line of treatment, which also improves health outcomes.

Tambuyzer et al. (2014) review how concepts including patient involvement, shared decision-making and empowerment show that these concepts are used in numerous ways, leading to conceptual vagueness. However, the main barrier to patient involvement, to nurturing of empowerment and welcoming of patient agency, is to find practical ways to shape them, i.e., how to create conditions for patients, carers and professionals that enable patient involvement.

Edwards, Davies and Edwards (2009) differentiates between i) empowered patients who can enter into a negotiable exchange of information, ii) non-empowered patients who do not seek information or who are reluctant to discuss information in the encounters, or iii) dis-empowered patients who are not given access to information exchange and participation in the encounters with professionals (ibid.). In health related situations, patients are likely to question the suggested assessments, evaluations or interventions, e.g., how will this treatment regimen affect my social life? How will side effects worsen my health? Do I want a second opinion? Will my family support the choices and decisions I have made? Whether these questions are brought forward in the health encounter or only in confidence with a friend can be related to empowerment, as Edwards et al. suggests. In health and social sciences, discussion as to how patients are empowered or exercise agency is often interpreted in light of paternalism. Paternalism in the system might be expressed when the professional not only gives help according to needs, but also to a great extent defines the needs on the behalf of others (Edwards et al., 2009). However, this rules out the possibility that refusing to take part, to leave decision-making to healthcare providers or proxies, is a vital sign of communicative capacity and agency. Refusal may be an utterance from an empowered patient.

General practitioner Jannecke Thesen, whose staircase to oppression was illustrated in figure 2, has devised an alternative staircase for recuperative health encounters.

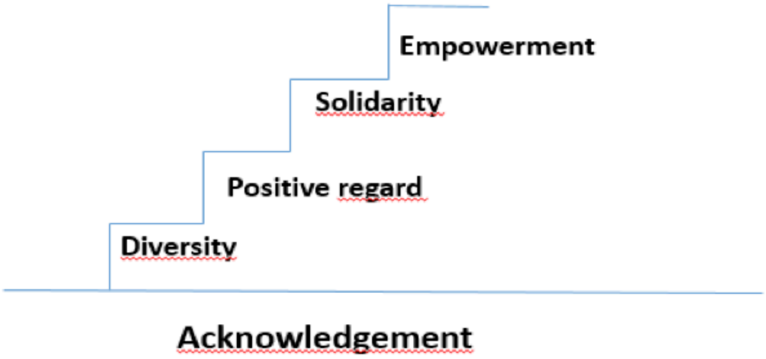

Figure 4. Staircase to empowerment (Thesen, 2005)

The central point here is recognition, respect for ‘the other’ and a relation where both parties are seen as subjects. Acknowledgement implies that the patient should be seen as more than their symptoms. The medical gaze is not sufficient to be acknowledged as a person worthy of due respect: ‘*The actions and power to give self and others equal ability to define identity, equal and sufficient resources, and an equal voice in society*’. Solidarity in practice can be listed as the positive regard that implies paying attention to the person’s resources, where stereotypes are replaced with diversity and positive expectations. Finally come solidarity and empowerment as opposed to discrimination and oppression (ibid.:51).

As a GP, Thesen takes as a point of departure that many health related concerns are long lasting or lifelong, as NCDs, and possible to treat (or leave untreated) in numerous ways.

Modern day health concerns often have a considerable impact on everyday living for patients (and next-of-kin), and impacts on possibilities for participation in productive occupations (school, work) or leisure (athletics, religion, community, friendship). Decisions and recommendations for how to live with such health challenges must be decided upon by climbing the stair to empowerment together: physician(s) and the patient (and their significant others) during face-to-face interaction. Communication is the key.

## Conclusion

In this article we have questioned how the underlying premises in intercultural communication, tolerance and the culture of medicine may intersect in such ways that empowerment and shared decision-making in health can be constrained. The historical tenets of medical culture and intercultural communication are deeply rooted in paternalistic approaches to the subject of interest – the patient or the interlocutor from a 'different culture'. We acknowledge that these historical trends are giving ground, but caution that new versions of tolerance might serve as a reiteration of old paternalistic positions. If tolerance is a response to aversion, we risk creating the healthcare provider as a morally superior subject – at odds with the ideas underpinning the staircase to empowerment and shared decision-making in health encounters. The body of knowledge on interaction in healthcare and intercultural communication could profit on interpreting face-to-face interaction as situated social practice. Critical learning and curiosity about the subject of interest – the interlocutor or patient – fertilizes the ground for changing the perspectives from tolerance and intercultural communication to empowerment and shared decision-making.

The literature presented above leaves no doubt about the emergent challenges in health encounters between minority patients and their healthcare providers. The critical body of knowledge on intercultural communication and on tolerance underscores these challenges. However, as Brown (2009) states, interaction on a micro level is not a priori at odds with the humanistic and hermeneutic positive sides of tolerance. Theories of intercultural communication, as other theoretical constructs, are lagging behind innovative practice and new interpretive frames. We suggest that framing a health encounter between minority patients and their healthcare providers as social action makes a promising way forward. Sociological theory on social interaction adds value to other studies of intercultural interaction and co-existence.

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