The Production and Maintenance of Inequalities in Health Care
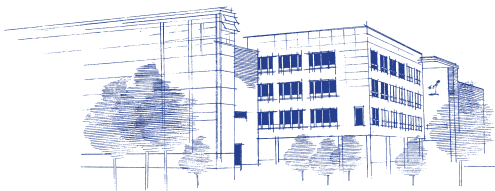
A communicative perspective

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ABSTRACT

The Swedish health care system does not offer care on equal terms for all its end-users. Discrimination toward patients can take the form substandard communication toward women or foreign born patients. Discrimination is also embedded in the organizational context. Health care is under pressure to increase efficiency and quality of care at the same time. There is a risk that demands for equality will be pushed aside. This thesis aims to contribute to our understanding of how discrimination is expressed in interpersonal- and organizational communication within health care, and highlight educational implications for health care practices. This thesis is comprised of three empirical studies and one conceptual study. In the first study, critical discourse analysis (CDA) is used to categorize gender patterns in communication between health care workers and patients, and finds that both patients and health care workers reproduced the gender order. Open questions created a setting less prone to be limited by gender stereotypes. In the second study, CDA is used and complemented with Linell's dialogic perspective in order to explore whether patients who were native speakers of Swedish were constructed differently than those who were not, in patient-physician consultations. Findings indicated that the non-native speakers actually were model, participative patients according to patient-centered care. Notwithstanding this they were met by argumentation, whereas the more amenable native patients were met by accommodating responses. In the third study, qualitative content analysis is used to analyze how health care workers talked about patients in their absence. The results revealed that communication about patients who were perceived as not acting according to socially accepted gender norms contained negative and disparaging statements. The final study focused on Clinical Microsystems, a New Public Management-based model for multi-professional collaboration and improvement of health care delivery. Drawing on theories of New Public Management, gender, and organizational control, this study argues that the construction of innovative and flexible health care workers risks reproducing the gender order. The thesis concludes that gender and ethnic stereotypes are reproduced in health care communication, and that an efficiency-inspired organizational and institutional discourse may be an impediment to equal care. This calls for focus on learning about communication for prospective and existing health care workers in a multicultural health care context.

ORIGINAL PAPERS

PAPER I

Hedegaard, Joel., Ahl, Helene., Rovio-Johansson, Airi., & Siouta, Eleni. (2014). Gendered communicative construction of patients in consultation settings. *Women & Health*, 54(6). Accepted for publication.

PAPER II

Hedegaard, Joel., Rovio-Johansson, Airi., & Siouta, Eleni. (2013). Communicative Construction of Native versus Non-Native Swedish Speaking Patients in Consultation Settings. *Scandinavian Journal of Public Administration*, 17(4), 21-47.

PAPER III

Hedegaard, Joel. (2014). Communication about patients in multi-professional teams: A gender perspective.

PAPER IV

Hedegaard, Joel., & Ahl, Helene. (2013). The Gender Subtext of New Public Management Based Work Practices in Swedish Health Care. *Equality, Diversity and Inclusion*, 32(2), 144-156.

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ACKNOWLEDGMENTS

The six years that have taken me to complete my doctoral studies and write this thesis, have been characterized by many different but parallel journeys; including intellectual, emotional, and physical journeys. Hopefully, I have developed my intellectual skills (or at least I have learned to better give the illusion of being intellectually skilled). Without a doubt, I am 'more married' and more of a parent than I was when I started this adventure. I am also chronologically six years older, and from some of my experiences, I have almost become an elderly person. This is one way of framing these past six years. Another is to refer to the immediate environment in which my studies were undertaken, and highlight the different fellow-beings therein, who influenced me during this transformative period.

Primarily, the School of Education and Communication (HLK) in Jönköping, and the entire set of fine fellow-beings, former, and current colleagues active there (including those who are now employed at the University Services department), have to be mentioned for creating a stimulating and highly enjoyable work environment. I especially want to thank those with whom I shared an office corridor up on the third floor. You have all, in different ways, contributed to my well-being, often reaching unprecedented heights. It has been extremely important for me to be able to pop in to your respective rooms and have interpersonal meetings, where we talked about different issues. It was a real pleasure being 'locked up' with you all.

At HLK, my research affiliation was within the research area of 'Lifelong Learning' at the National Centre for Lifelong Learning (Encell), where two of my supervisors were based. First, I would like to express

pecially want to single out the sub group within 'Bridging the Gaps I' that shared a common interest in learning, of which I was fortunately enough a part. Led by Professor Lena Fritzén, this intimate little group, which also included Ann-Charlott "Karlotta" Norman, Karin Thörne, and Katherine Stevenson, gave me the opportunity to get closer to, and hopefully in some respect develop a more nuanced attitude towards health care via the concept of learning. From 'Bridging the Gaps II', I particularly want to thank Eleni Siouta for your generosity when you shared your hard-won empirical data with me.

I also want to give my warmest thanks to those who, at the different milestones during my doctoral studies, have examined my texts and delivered very valuable comments on the various versions of the thesis: discussant Elisabeth Cedersund and the two members of the reading group, Christian Eidevald and Tobias Olsson, at the mid-way seminar, and, discussants Maria Gustavsson and Klas Borell and Susanne Kvarnström, who were part of the reading group at the final seminar. Elisabeth Cedersund also had the indubitable pleasure of being a discussant at my very first seminar, the so-called 'planning seminar'. A special thanks to you for giving me guidance with respect to the initial sprawling body of text, and for pointing out potential directions in the early stages. I would also like to thank Arne Gerdner and Mats Granlund for invaluable advice and assistance with the ethics application.

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Finally, I would like to thank my wife Petra and my daughter Lily. You two constitute a home in its finest and most significant form.

ENGLISH AND SWEDISH NAMES, CONCEPTS AND ABBREVIATIONS

Several of the names and concepts referred to and used in this thesis, have a Swedish origin. Therefore, they will, when mentioned the first time, be written in Swedish and with the English translation in parentheses. The English terms will subsequently be used throughout the thesis with the exceptions of when there are long intervals between the instances when the names and concepts are mentioned, and in references in parentheses where the original term is used. The occurrence of abbreviations in this thesis is frequent. This includes both Swedish and English names and concepts. They are thus included in the following figure in order to clarify the connection between the different names and concepts, and their respective abbreviations.

English	Swedish	Abbreviation used
Atrial Fibrillation	Förmaksflimmer	AF
Clinical Microsystem	Kliniska Mikrosystem	CM
Critical discourse analysis	Kritisk diskursanalys	CDA
The Equality Ombudsman	Diskrimineringsombudsmannen	
Government Offices of Sweden	Regeringskansliet	
Jönköping County Council	Jönköpings landsting	
Ministry of Education and Research	Utbildningsdepartementet	
Ministry of Health and Social Affairs	Socialdepartementet	
Ministry of Justice	Justitiedepartementet	
National Social Insurance Board	Riksförsäkringsverket	
Native Swedish speaking patient	Patienter med svenska som modersmål	NS
New Public Management		NPM

Non-native Swedish speaking patient	Patienter utan svenska som modersmål	NNS
Open comparisons	Öppna jämförelser	
Patient-centered care	Patientcentrerad vård	PCC
Quality Care	God vård	
Statistics Sweden	Statistiska centralbyrån	
Swedish Association of Health Professionals	Vårdförbundet	
Swedish Association of Local Authorities and Regions	Sveriges Kommuner och Landsting	
Swedish Government Official Reports	Statens offentliga utredningar	
Swedish Statute Book	Svensk författningssamling	
The Health and Medical Services Act	Hälso- och sjukvårdslag	
The Health care Profession Act	Lagen om yrkesverksamhet på hälso- och sjukvårdens område	
The National Board of Health and Welfare	Socialstyrelsen	
The National Dental Service Act	Tandvårdslagen	
The Swedish Agency for Health and Care Services Analysis	Myndigheten för vårdanalys	
The Swedish National Audit Office	Riksrevisionen	
The Swedish National Institute of Public Health	Folkhälsoinstitutet	
The Swedish Research Council	Vetenskapsrådet	
The Swedish Social Insurance Agency	Försäkringskassan	

Table 1. Overview of the Swedish and English names used in this thesis, and their abbreviations.

INTRODUCTION

Discrimination that is due to stereotypes and prejudices, or the exclusion of an individual or a group that is based on their social positions[1], occurs everywhere. The problem with discrimination is not that it is based on any specific geographic-, cultural-, or institutional type. Rather, it can be considered a simple consequence of human interaction (Abrams, 2010; Illeris, 2001; Schneider, 2004) and antagonistic interests (Johnsdotter, 2007). The present research is set within a health care context, where the results and the consequences of discrimination are perhaps even more serious than in other contexts. By examining the cases that were filed at Diskrimineringsombudsmannen (The Equality Ombudsman) in Sweden in 2009, it was found that access to health care was unequally distributed among individuals and groups. Furthermore, problems associated with discriminatory attitudes were so severe that they influenced people's willingness to seek care (Diskrimineringsombudsmannen, 2012). Once problems with accessibility are overcome, and people attend health care, new forms of inequality occur; for instance, in

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[1] The term *social position* is understood as including factors that influence an individual's status and potential opportunities in society (Lindemann, 2007). Social position will be further described in the discussion of the theoretical and conceptual framework that was used in this thesis, in Chapter 3.

the form of different medical treatments being made available to different patient groups (Diaz, 2009; Risberg, 2004; Risberg, Johansson, & Hamberg, 2009; Socialstyrelsen, 2004; Szczepura et al., 2005), as well as certain patient groups feeling poorly treated by health care workers (Abrums, 2004; Arber et al., 2006; Basnett, 2003; Thornton, Powe, Roter, & Cooper, 2011; Upmark, Borg, & Alexandersson, 2007).

However, as Ahlberg and Krantz (2006) point out, discrimination can- not solely be attributed to individual behaviour. The framework within which individuals expose others and are themselves exposed to discrimination is established by the dominant organization and the institutional discourse that emerges in that organization, which, in turn, in various ways and due to different reasons, may facilitate (or obstruct) this type of behaviour. Therefore, it is important to view the individual health care worker, or the different health care teams, as part of an institution in which discrimination is structurally incorporated, and to develop organizational support so as to raise awareness on a collective-, as well as an individual level with respect to these challenges. It is thus crucial to investigate how discrimination is enacted in practice and how this is embedded in an organizational and institutional context.

My research interest in education implies that discrimination will be explored from a communicative perspective. Communication in this respect is understood as a 'mediating tool for learning' (Linell, 2009), with reference to the construction of social identities as

they appear in the health care settings that were examined for this thesis. Communication in health care obviously comprises verbal and interpersonal conversations (Wynia & Osborn, 2010), both among health care workers, and between health care workers and their patients. However, communication is also an important part of the implementation of policies and management models that are designed to influence the organizational and institutional discourse (LeGreco & Canary, 2011), as well as in the further education of health care professionals (Bacon & Newton, 2014).

Calderon and Beltran's (2004) definition of health communication as "the dissemination of understandable and usable information that concerns itself with health" (p. 1), captures, in many respects, the communicative diversity that this thesis intends to explore. It includes verbal interpersonal communication both between health care workers and patients, as well as among health care workers. It also incorporates mediated directives and policies that are implemented with the intent to influence health care practice and its organizational and institutional context.

Previous research on verbal interpersonal communication and discrimination has primarily focused on communication between health care workers and patients, with an emphasis on the communicative contributions of the former. Studies have focused on unconscious assumptions that are held by the health care workers (see for instance Burgess, van Ryn, Dovidio, & Saha, 2007; Dovidio et al., 2008; van Ryn & Fu, 2003), while the role of patients' communicative contributions have largely been overlooked. Thus, this relational and dialogic phenomenon has

primarily been recognized from a non-relational and monologic perspective. This study adds to the existing research on verbal interpersonal communication in health care by including the role of the patient. Furthermore, health care workers communication *about* patients has been under-prioritized in previous research, at least when it comes to how the patients' social positions influence the communication. Communication about patients is important, since this contributes to form the professional culture and identity of health care workers, which, in turn, has bearing on how they meet patients (Lingard, Reznick, DeVito, & Espin, 2002). This study complements the available research by ex- ploring the (thus far) unexplored subject of the health care workers' communicative construction and categorization of patients in their (the patients') absence. In addition, the focus in previous research on verbal interpersonal communication in health care has predominately been on the micro-level, whereas the organizational and institutional level, which undoubtedly influences the micro-level, is often ignored (Ackerson & Viswanath, 2009). This study also adds to existing research by situating the communication in the context of an organizational and institutional discourse (Agar, 1985; Linell, 1998, 2009), thus providing the reader with an extended understanding of how discriminatory mechanisms work, and are communicated and negotiated, along with their implications for health care practice.

The communicative focus in this thesis also includes the organizational and institutional discourse, for example, in written directives and poli- cies, but also instances when these

directives and policies are transformed i n t o m a n a g e m e n t models that have goal to change health care practices. Over the last few decades, Swedish health care has become increasingly influenced by New Public Management (NPM) (Hood, 1991, 1995) and its associated performance paradigm (Anell, Glenngård & Merkur, 2012), which has affected and continues to affect the organizational a n d i n s t i t u t i o n a l c o n d i t i o n s t h a t p r e v a i l w i t h i n h e a l t h care in Sweden (Abrahamsson & Johansson, 2008; Hasselblad, Bejerot, & Gustafsson, 2008; Målqvist, Åborg, & Forsman, 2011; Rovio-Johansson & Liff, 2012). Even if critical studies exist, much of the previous re- search in this area has focused on the efficiency aspects of the various models, and the tools that are advocated by these different directives and policies (Bergmark, 2008; Magnussen, Vrangbaek, & Saltman, 2009; Williams, Dickinson, & Robinson, 2007). As a consequence of this strong focus on efficiency and control, other aspects have often been overlooked; for instance, equality implications (Standing, 1997; Stand- ing, 2000). This research aspires to fill this gap by looking at two par- ticular organizational and institutional discourses inspired by NPM, namely patient-centered care (PCC) (Socialstyrelsen, 2009b; Svensk författningssamling, 1982), and Clinical Microsystems (CM) (Mohr & Batalden, 2002; Nelson, Batalden, & Godfrey, 2007).

This thesis is written within the research projects 'Bridging the Gaps I' and 'Bridging the Gaps II', with a medical/health care residence, and with the common ambition to scientifically evaluate and further develop the quality and improvement work within

health care in Jönköping County Council. More specifically, 'Bridging the Gaps I' was intended to contribute to sustainable and deep improvements in the patient- and population health outcomes by improving system performance, and to enable better continual professional development. The project focused on two areas in particular, which, taken together, may increase the value (care) for the patient and the population. These areas include the inno- vative redesign of work processes, and increased patient involvement in the development of care (Jönköpings landsting, 2007). While 'Bridging the Gaps I' had a broad approach to these, by trying to enable overall improvements and changes from an organizational perspective (although it did include the patients' perspective), 'Bridging the Gaps II' had an explicit patient focus with two specific patient groups as targets; individuals with Atrial Fibrillation (AF) and patients who suffer from heart failure. The overall aim with 'Bridging the Gaps II' was to strengthen the patients' and their relatives' involvement in care by giving them the roles of (i) co-creators (active contribution in the development of care), (ii) co-producers (increased responsibility for some parts of the care), and (iii) co-evaluators of care (active evaluation of the quality of the care) (Jönköpings landsting, 2008). In this respect, my individual sub-project (one of 22 projects in total within the two research projects) delivers insights into how the system (organization) can improve its performance (cure and care-giving duties) by examine how its collabourators (patients) are being verbally and communicatively treated by the performers/professionals (health care workers). On this basis, it is also possible to subsequently give contributions to and suggestions

on the areas of health care and its practice which would benefit from further development, at least from a communicative and equality perspective.

This thesis is comprised of four studies that are reported in four papers. The first study investigates consultations between health care workers (nurses and physicians) and patients, focusing on how gender is socially constructed in verbal communication. The second study explores consultations between physicians and patients and focuses on differences between consultations with native versus non-native Swedish-speaking patients (NS and NNS respectively), and discusses the findings in reference to patient-centered care (PCC). The third study examines how health care workers communicate *about* patients when they are not there. It compares communication between two different sets of multi- professional teams – nurse/assistant nurse teams versus nurse/physician teams, during ward rounds and verbal handovers. The fourth study analyzes the literature on gender, on NPM, and on control theories, in order to develop a framework for researching the gender equality implications associated with the CM health care management model, which is inspired by NPM. These four studies add to the overall aim of the thesis, as presented below.

AIM

The overall aim of this thesis is to contribute to our understanding of how discrimination is expressed in interpersonal and organizational communication within health care, and to highlight educational implications for health care practice. The thesis is comprised of four papers with individual purposes, but these purposes are all incorporated under the overall aim that was mentioned above.

Below, the individual purposes of each of the four papers are presented:

1. To explore whether, and in such cases how, patients were reciprocally verbally constructed as male and female patients in communication with health care staff in consultation settings (Paper I – *Gendered communicative construction of patients in consultation settings*).

2. 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 care (Paper II – *Communicative construction of native versus non-native Swedish speaking patients in consultation settings*).

3. To study gender patterns in how two multi-professional teams communicate about patients in their absence (Paper III – *Communication about patients in multi-professional teams: A gender perspective*).

4. To propose a theoretical framework for researching gender equality implications of Clinical Microsystems, a new public management-based model for multi-professional collaboration and improvement of health care delivery. (Paper IV – *The gender subtext of New Public Management-based work practices in Swedish health care*).

STRUCTURE OF THE THESIS

This thesis consists of eight chapters. After this initial introductory chapter, discrimination is defined and explored from a conceptual perspective and from a legislative perspective in Chapter 2. The third chapter contains the theoretical and conceptual framework used in this thesis. In this chapter, central concepts, in addition to 'discrimination', are investigated from a social constructionist perspective. In the fourth chapter, the methodological points of departure that were used in the four papers (especially with respect to the three papers that refer to empirical studies) are presented. The fifth chapter is based on the findings of the four papers. In the sixth chapter, the main findings from the four studies are discussed with reference to the overall aim of the thesis. In the seventh chapter, conclusion is drawn and implications are made from the lessons learned throughout this thesis and finally, in the eight chapter, I point out limitations and suggestions for future research.

DISCRIMINATION IN HEALTH CARE

In the first section of this chapter, the concept 'discrimination' will be defined. The reason for defining what discrimination is at this point is because it is the key concept that is used in this thesis; it constitutes the actual research phenomenon. Other central concepts, such as 'social position', 'gender', 'ethnicity', 'communication', and 'organization', that are part of my theoretical and analytical framework, are defined in chapter three together with further elabouration on the concept 'discrimination'.

In the second section of this chapter, I situate discrimination in the context of the provision of health care by examining different governing documents that reference discrimination and equality, and which individual health care workers, multi-professional teams, and health care as an organization must adhere. In the third and fourth sections, I discuss previous research on discrimination in general and within health care respectively, especially research that is linked to the two prominent social positions that are explored in this study – gender and ethnicity. The final section summarizes the chapter and highlights some critical gaps in previous research; in reference to (i) discrimination in health care, in reference to (ii) verbal interpersonal communication, and in reference to (iii) the organizational context and institutional discourse.

DISCRIMINATION AND RELATED CONCEPTS

How, then, does discrimination differ from similar phenomena like stereotypes and prejudices? A common definition of *discrimination* is that it is action-oriented in the sense that it is constituted by actions that create and lead to disadvantages and the exclusion of an individual or a

group based on their different social positions (Fredman, 2011; Heckman, 1996; Svensk författningssamling, 2008)[2]. In this respect, discrimination differs from stereotypes and prejudices in that these two phenomenon affect thoughts, feelings, and assumptions about an individual or a group based on their different social positions (Whitley & Kite, 2010). Discrimination thus becomes an effect of stereotypes and prejudices, but as Dovidio, Brigham, Johnson and Gaertner (1996) point out, they may also be consequences of discrimination in that they are used to justify existing discriminatory situations, for example, in situations where someone claims that foreign-born patients have themselves to blame if they get substandard care because they do not want to learn the prevailing language.

Furthermore, a distinction is often made between different *types* of discrimination. For instance, in the Swedish Discrimination Act[3] (Svensk författningssamling, 2008), discrimination is divided into five different types: *direct discrimination* (disadvantage through being treated less favorably than another who is, has been, or would be in a comparable situation); *indirect discrimination* (disadvantage due to the application of a pro-

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[2] In some encyclopedias and dictionaries (for instance, the *Merriam-Webster* and *Oxford* dictionaries), *discrimination* is also defined as 'the ability to understand that one subject/thing is different from another subject/thing'. Thus, discrimination may also refer to a distinction without any valuation, which nevertheless is a prerequisite for a value discrimination. Henceforth, it is the latter definition of *discrimination* that will be used in this thesis.

[3] On January 1 2009, the previous four discrimination acts were merged and became one overarching act.

vision, criterion, or practice which appears neutral); *harassment* (violation of a person's dignity); *sexual harassment* (violation of a person's dignity due to conduct of a sexual nature); and *instruction to discriminate* (orders or instructions to discriminate given to someone who is in a subordinate or dependent relationship with the person who gives the orders or instructions). These types of discrimination recur in many countries' discrimination Acts. In the UK's Equality Act (Parliament of the United Kingdom, 2010), four additional types of discrimination are presented: *discrimination by association* (disadvantage against someone because they associate with another person who possesses a so-called 'protected characteristic'); *perception discrimination* (disadvantage against an individual because others think they possess a particular protected characteristic and it applies even if the person does not actually possess that characteristic); *third party harassment* (for employers – harassment of employees by people (third parties) who are not employed at the company (such as customers or clients); and *victimization* (disadvantage of a person because he/she has made or supported a complaint or raised a grievance under the Equality Act or because he/she is suspected of doing so. What all of these types of discrimination have in common is that they are action-oriented in the sense that they are an effect or a consequence of being exposed to discriminatory behaviour, either from an individual or from a societal/organizational perspective.

Besides the different types of discrimination mentioned above, divisions can also be made based on the different *forms* of discrimination. The basic distinction in these cases is that between individual discrimination and collective discrimination (Fiske, 2000; Heckman, 1996). There appears to be consensus on what individual discrimination entails. It concerns the behavior of an individual that is to have a differential and/or

harmful effect on another individual based on his/her social position (Fiske, 2000; Hansen & Sassenberg, 2006; Pincus, 2000). Collective discrimination is, however, more complex. Pincus (2000) makes a distinction between institutional discrimination and structural discrimination. What differentiates the two forms of discrimination is that institutional discrimination is dehumanized in the sense that it is found purely in the content of policies, while structural discrimination refers to the implementation of these policies. A more articulate presentation of the distinction between the two collective forms of discrimination is found in a Swedish Government Official Report on discrimination, wherein institutional discrimination is understood as synonymous to organizational discrimination, while structural discrimination is defined as societal (Statens offentliga utredningar, 2006b).

Discrimination can also be differentiated based on the presence and/or absence of intent (Banaji & Dasgupta, 1998; Devine, 1989). However, proving the presence and/or absence of intent falls outside the scope of this thesis. Consequently, my point of departure is based on the assumption that the discrimination that has been researched within the frame of this thesis is unintentional and unconscious. In this thesis, I scrutinize direct and indirect types of discrimination, together with individual and structural forms of discrimination. In connection to this, I readily employ Pincus' (2000) distinction between institutional discrimination and structural discrimination, because it is not reasonable to claim that the policies that are advocated for in the health care system as discriminatory in themselves, at least not directly. Thus, the division between policies, on the one hand, and their implementation, in the other, is of such importance in my investigation.

With the concept 'discrimination' now being defined and put into a leg-

islative perspective, it is time to move on to health care and the policies that are relevant to discrimination.

HEALTH CARE'S GOVERNING DOCUMENTS

This section provides a discussion of the national and international laws and policies that have bearing within health care provision, with reference to discrimination in Sweden. A new concept is also introduced here, namely 'equality'. 'Equality' can be understood as an attempt to provide a positive reformulation of 'discrimination'. To deliver equal care (Socialstyrelsen, 2006), discrimination needs to be addressed, or rather eliminated, and replaced by equality. First, I discuss general policies, where equality is a part of these policies. This is followed by two additional policies, which are more specifically oriented towards equal care and human rights.

REGUALTORY ACTS

The regulatory act, *God Vård* (Quality Care) (Socialstyrelsen, 2006)[4], established the basis for systematic quality work in Swedish health care. This act highlights key principles of systematic quality work within health care, and are expressed in three of the most extensive and important laws that regulate Swedish health care: *Hälso- och sjukvårdslagen* (The

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[4] This act is based on the American report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Committee on Quality of Health care in America, 2001).

Health and Medical Services Act); *Lagen om yrkesverksamhet på hälso- och sjukvårdens område* (The Health care Profession Act)[5]; and *Tandvårdslagen* (The National Dental Service Act) (Socialstyrelsen, 2006).

These laws set the standards for what quality health should entail for the individual citizen, and they give directives to health care workers as well as to health care management on how care should be developed, secured, and organized. The key principles that crystallize from the above-mentioned laws, constitute the definition of *Quality Care* as safe, knowledge-based, patient-oriented, effective, timely, and equal. On the topic of *safety*, it is stressed that health care management must be organized in such a way that it meets high patient security demands. Safe health care is a cornerstone in all quality work, and it means that any lapses in patient security must be prevented through active risk prevention activity. Regarding the demand that care shall be *knowledge-based*, staff must carry out their work in agreement with prevailing science-based evidence and reliable experience, and patients shall be provided with competent and careful care that meets these requirements. In the matter of *patient-centred care*, the law states that care must, to the largest extent possible, be formulated and implemented in consultation with the patient, who must be shown thoughtfulness and esteem. The health care workers responsible for the care of patients must ensure that patients are given individually-tailored information about their health condition, and information about the methods of examination, care, and treatment that are available. Concerning the demand on *efficiency*, health care management must be organ-

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[5] The act was repealed on January 1, 2011 and replaced by *Patientsäkerhetslagen* (The Patient Safety Act).

ized in such a way that it meets high levels of patient security, promotes the provision of good quality care, and promotes cost effectiveness. The demand with respect to *timelines*, establishes the practice that each patient who comes into contact with a health care provider must be given a medical assessment of their health condition as soon as possible (if it is not clearly unnecessary). Finally, the demand on *equality* emphasizes that fact that the objective of health care is the promotion of good health, and the provision of health care on equal conditions for the whole population. Care must be given with regards for everyone's equal value and for the dignity of the individuals, and it is urgency of a patient's immediate needs that should determine who will be given precedence in receiving care (Socialstyrelsen, 2006). The demand for *equality* is of primary interest in this research, but I will also return to the other demands, especially as they may emerge as competing ideals in relation to the demand of equality.

THE RIGHT TO HEALTH

The right to health is a fundamental human right and forms part of our understanding of a life with dignity. The right to the enjoyment of the highest attainable standard of physical and mental health was originally formulated in the 1946 *Constitution of the World Health Organization* (World Health Organization, 1946), whose preamble defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (p. 1). The preamble further states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." Twenty years later, in the *Covenant on Economic, Social and Cultural Rights* (article 2, para-

graph 2), several additions were made, identifying the following non-exhaustive grounds of discrimination: *color*, *sex*, *language*, *political or other opinion*, *national or social origin*, *property*, *disability*, *birth or other status* (The Office of the High Commissioner for Human Rights, 1966). Seventeen years later, they made yet another addition to the 1946 Constitution of the World Health Organization including *sexual orientation* as a "protected" position (The Office of the High Commissioner for Human Rights, 1993).

These internationally recognized norms are a set of legal standards, which many governments have agreed to promote and protect. Hence, it is a government's responsibility to progressively ensure that direct violations of these laws are prohibited, but also a government's responsibility to be party to the creation of conditions that enable individuals to exercise their right to health as fully as possible. Today, every country in the world is committed to at least one treaty that encompasses health-related rights, and is therefore responsible for reporting periodically to an international monitoring body on its compliance (Braveman & Gruskin, 2003). In summary, the right to health is constituted by five principles;

1. The right to health is an inclusive right (underlying determinants of health).
2. The right to health contains freedoms (none-damaging aspects).
3. The right to health contains entitlements (access to health care and treatment).
4. Health services, goods, and facilities must be provided to all without discrimination.

5. All services, goods and facilities must be available, accessible, acceptable, and of good quality (Office of the United Nations High Commissioner for Human Rights & World Health Organization, 2008).

Principle four (above) is considered to be the key principle (Office of the United Nations High Commissioner for Human Rights & World Health Organization, 2008), and it is linked to the marginalization of specific social positions that, in general, are victims of fundamental structural inequalities. These inequalities contribute to a higher degree of vulnerability for individuals regarding poverty (who also manifest a disproportionate share of health problems). Each country has an obligation to prohibit and eliminate discrimination on any grounds and ensure equality for all in terms of access to health care, as well as to control the underlying determinants of health. It further implies that states must recognize and provide for different and specific needs of groups that generally face particular health challenges, especially for groups who have been previously exposed to discrimination; for instance, women, children, people with disabilities, migrants, and people with stigmatizing illnesses such as HIV/AIDS.

EQUAL HEALTH CARE

A key feature in the laws and the regulatory acts mentioned in the previous sections, namely 'equal health care', demands that care be provided and distributed on equal conditions for everyone (Socialstyrelsen, 2006). Equity in health reflects a concern with reducing unequal opportunities with respect to becoming healthy and staying healthy. These

unequal opportunities are associated with different social positions, such as socio-economic status, ethnicity, religion, sex (especially women), and residential status (e.g. rural residents). In operational terms, pursuing equity in health entails:

> [e]liminating health disparities that are systematically associated with underlying social disadvantage or marginalization. An equity framework systematically focuses attention on socially disadvantaged, marginalized, or disenfranchised groups within and between countries, including but not limited to the poor. (Braveman & Gruskin, 2003, p. 540).

The demand for equal health is closely linked to the fourth principle that is expounded in the *Right to Health* (World Health Organization, 1946), and like the fourth principle it highlights potential injustices and discrimination that health institutions ultimately need to address by systematically considering how the design or implementation of policies and programmes may, directly or indirectly, affect social marginalization, disadvantages, vulnerability, or discrimination (Socialstyrelsen, 2006).

The above overview of several relevant legislative and policy documents shows that there exists a strong and unanimous agreement that discrimination must not occur. However, it still does occur; which is the topic of the next section.

PREVIOUS RESEARCH ON DISCRIMINATION

In this section, I discuss previous research on discrimination. I have limited the discussion to discrimination on the grounds of gender and

ethnicity, since these social positions are my research focus. I begin by discussing discrimination on the grounds of gender and ethnicity from a general perspective, and then move on to research on discrimination linked to these two social positions in the context of health care.

GENDER DISCRIMINATION

Stereotyping gender and ascribing certain attributions and qualities to women and men is common practice in Sweden and elsewhere. Stereotypes about women are that they are, for instance, emotional, understanding, careful, and considerate (Eagly & Karau, 2002; Kite, Deaux, & Haines, 2008), while stereotypes about men are that they are controlling, competitive, independent, and self-confident (Ahl, 2006, 2007; Eagly & Karau, 2002; Koenig, Eagly, Mitchell, & Ristikari, 2011). Such stereotypes may also be reflected in female and male self-images or are internalized as personal dispositions (Brown & Diekman, 2010; Wood & Eagly, 2009). At first glance, harbouring gender stereotypes and prejudices might appear to be relatively harmless, but in practice they often have problematic consequences. This is especially true for women in particular (as indicated by gender being identified as one of the protected social positions in the discrimination and equality acts, as well as in the declaration of the *Right to Health*, where women are identified as the more aggrieved sex). These gender stereotypes and prejudices have both descriptive and prescriptive features (Eagly, 2009), indicating both what women and men usually do, but also what they should do. These features thereby run the risk of being transformed from mere harboured stereotypes and prejudices, to becoming action-oriented precursors of pure discrimination. To be, or rather being *perceived* to be, considerate and nurturing makes women suitable for working in, for instance, the

service and welfare sector (Eagly & Karau, 2002), which indeed happens to be the sector where most Swedish women work (Statistiska central-byrån, 2012a). When ascribing characteristics such as being high-performing and autonomous to men, men then tend to be seen as fit for a leadership role, for example (Ahl, 2006). This has apparently taken place, since about twice as many men hold managerial positions in Sweden than women (Statistiska centralbyrån, 2012b). Thus, this division between the sexes also includes values that perpetuate notions of superiority and subordination, patriarchy, and hegemony. Besides the female/male dichotomy, a hierarchy emerges. Interpersonally, the effect of this is that males are socialized to dominate over the none-male representatives (i.e., females, but also men that are not perceived to embody masculine norms) (Connell, 1995; Kimmel, 2006).

These stereotypes and prejudices are based on a separation between the sexes (Acker, 1992), and on the view that women and men are each other's opposites, but complementary to each other. There are, of course, complementary and conflicting ideas surrounding this notion of gender segregation, including the observation that such stereotypes and prejudices are changing. Both Diekman, Goodfriend and Goodwin (2004), as well as Greene and DeBacker (2004), argue that a changed mindset regarding women and their suitability for power has emerged, and, according to Hearn et al (2012), the notion of hegemonic masculinity is in decline, at least in the Swedish middle-classes. Moreover, opposite to the commonly held *Gender Difference Model* (or separation of the sexes as suggested by Acker), Hyde (2005) proposes a *Gender Similarities Hypothesis* which is critical of the "overinflated claims of gender differences" (p. 590). Despite this opposing alternative, traditional gender

stereotypes still seem to inform the prevalent discourse as "the dichot-omy of male and female is the ground of which we build selves from the moment of birth" (Eckert & McConnell-Ginet, 2013, p. 15).

These stereotypes and prejudices are also embedded in larger societal systems, such as political, legal, cultural, and economic systems. Such systems embed resource allocation and power that is typically unequally distributed between the sexes. A system of inequality is thereby pro-duced and reproduced (Seguino, 2007). Thus, there is a relationship be-tween these ascribed female and male characteristics, and various forms of tasks, in both the personal- and working life. Work tasks are not even free from being gendered (Kvande, 2007). In Sweden, a country that often is acclaimed as one of the world's most gender equal countries, partly because of the high proportion of women in the labour market (Amundsdotter & Gillberg, 2001; Vänje, 2013), work segregation be-tween the sexes is apparent. More than 70 percent of men and women, work in male-dominated respective female-dominated (and lower paid) fields. In the labour market taken as a whole, only 14 percent of women and 12 percent of men, work in occupations with an equal gender dis-tribution[6] (Statistiska centralbyrån, 2010). Moreover, within the 30 larg-est occupations, only three of them have an equal gender distribution of employees (Statistiska centralbyrån, 2012a). Thus, labour market partici-pation is about equal for Swedish men and women, but their conditions on the labour market are not equal.

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[6] Equal gender distribution is defined as 40 to 60 percent of each sex being represented (Statistiska centralbyrån (Statistics Sweden), 2012a).

Furthermore, there exists an obvious glass ceiling (Morrison, White, & Van Velsor, 1994), which structurally prevents women from reaching high positions at work places and within organizations (for example, managerial positions) which consequently seem primarily reserved for men. Thus, the Swedish labour market is characterized by horizontal *and* vertical gender segregation. The reasons for this are many. Carlsson (2011) suggest that this state of affairs may be a result of the demands in terms of what is requested in the labour market (where we observe primarily men/'masculinity' in male-dominated occupations and women/'femininity' in female-dominated occupations). This is the case at least within some fields of work, but above all in the public sector. Primarily, the skewed supply of potential employees for the different fields of work is due to women's and men's choice of education and occupation. This is highlighted as the main reason for the segregated labour market (Carlsson, 2011). This, in turn, leads us back to stereotypes and prejudices, and the power they exercise in terms of influencing the educational choices made by women and men.

However, it is not only gender-marked education choices and the availability of different types of jobs that create different conditions for women and men. When we consider wages, we observe an unequal pattern of remuneration. Even though salary levels are becoming more and more balanced between the sexes, it is still the case that women employed by municipalities earn 99 percent of men's income for performing equivalent work duties, whilst the figures for county councils show that women, on average, earn 94 percent of the men's salary, and women who are employed by the state earn 91 percent of the men's salary (Statistiska centralbyrån, 2012a). The emergence of an informal

wage structure, which is not exclusively based on formal merits and linked to job characteristics, may explain this discrepancy in wage equality between the sexes (Johansson, Katz, & Nyman, 2005). The segregated labour market is also believed to influence levels of remuneration. The various professions that women and men are active in possess different occupational status (Svensson & Ulfsdotter Eriksson, 2009; Ulfsdotter Eriksson, 2006). Femininity, which is usually ascribed to women, is often requested in caring and service professions with low status, whereas masculinity, commonly ascribed to men, is often required in high-status professions such as management of large corporations. Consequently, entrance to high-status occupations for women often requires "de-feminization" and a display of masculine ideals (Ulfsdotter Eriksson, 2006). On the other hand, when women display masculine ideals they may encounter negative reactions because they are perceived as too powerful and thereby threaten the prevailing gender order and hierarchy (Johnson, Murphy, Zewdie, & Reichard, 2008; Rudman, Moss-Racusin, Phelan, & Nauts, 2012).

Besides the apparent injustices regarding economic power and conditions on the labour market, household labour (domestic work) is also distinguished by an unequal division between the sexes (Statistiska centralbyrån, 2012a). In 2012, 75,6 percent of the parental leave days that were paid by the state were used by women, despite the fact that a special gender equality bonus was introduced in 2008. The effect of this change in legislation has, so far, been marginal (Försäkringskassan, 2013). Furthermore, Rothstein (2012) goes so far as to argue that the unequal balance of power between the sexes may even have bearing in terms of the choices women make in selecting a life-partner. Driven by

an economic rationality, some women seek out older, and economically strong, men due to their (the women's) expectation of having a weaker position in the labour market. This represents a social trap in which what seems as rational for an individual woman regarding economic prosperity is irrational for women's position in society (Rothstein, 2005). This type of economic rationality reproduces the unequal economic power relationship between the sexes, and thereby, reinforces the gender order.

Gender discrimination is thus common practice and widespread throughout Swedish society and elsewhere. Next, I will turn to previous research on the issue of ethnic discrimination in order to discuss its prevalence and consequences.

ETHNIC DISCRIMINATION

Regarding ethnicity, stereotypes and prejudices flourish. Even among children, the presence of ethnic stereotypes have been found (Pauker, Ambady, & Apfelbaum, 2010), and just as with gender stereotypes, ethnic stereotypes seem to have a firm grip on people's minds. For instance, Devine and Elliott (2000) investigated how prejudices towards African Americans has changed over time and found prejudice to be fairly constant; it has changed its form and become more subtle, but the content has not changed. In other words, burning crosses and wearing white sheets is no longer legally or socially acceptable, but the harbouring of disparaging perceptions is apparently harder to legislate against. In a study similar to Devine and Elliott's, Bobo (2001) highlights five trends related to ethnic stereotypes and prejudices. The first shows that the general attitude of Americans' regarding integration and equality has

improved over the last 30 years. However, the following trends are less positive. The second trend, according to Bobo, is that this change in attitude has not had any positive effect when it comes to creating better opportunities for African American and ethnic minorities. The third trend is similar to what Devine and Elliott observed: white Americans continuously express stereotyped and prejudiced views with respect to minority groups. Trend number four shows a difference in the perception of the prevalence of racial discrimination between white Americans and none-white Americans. White Americans do not perceive discrimination to the same extent as non-white Americans. Finally, the fifth trend, presents the most alarming patterns. This trend shows that in some environments and contexts, the level of alienation experienced by minorities has reached a higher level. To challenge these kinds of stereotypes and prejudices is not risk-free. Phelan and Rudman (2010) have found that so-called "counter-stereotypical actors" are penalized in ways which prevent them from continuing to challenge ethnic stereotypes, just as in the case with women who seek employment in high-status professions, for instance.

In Sweden, researchers have found similar negative stereotypes and prejudices (de los Reyes & Kamali, 2005b; de los Reyes, Molina, & Mulinari, 2006). Groglopo (2006) states that despite the fact that the notion of 'race' has long been dismissed as a scientific truth, ideas about race continue to be a permanent part of life and how society organizes its material, social, and symbolic resources. Today, the concept of 'culture' has replaced the old concept of 'race'" (with its biological connotations), but 'culture' leaves racism intact as a system which, on the one hand, creates privileges and domination and, on the other hand, subordina-

tion. 'Culture' is (as 'race' was) believed to explain people's 'essence', and hence, the social, political, and economic differences that exist in society (Groglopo, 2006). Regardless of the concept that is ultimately used (for example 'race', 'culture', 'ethnicity', or even 'nativity'), it is invoked to explain the kind of organizational or institutional arrangements that describe some groups as *different* or as 'the other' because of their 'race', 'cultural background', 'ethnicity', or 'nativity'. The power to define who is different is institutionalized with the aim of, often unconsciously, maintaining a power structure by dominant discourses of fixed identities, cultures, ethnicity, gender and sexuality. These patterns are created in an institutional context, in which the norms, rules, preconceived interpretations, and perceptions of 'us' and 'the other' maintain unequal power relations (Essed, 2005).

The presence of ethnic discrimination also becomes clear when we take a look at the Swedish labour market. This discrimination begins at the entry point to the labour market (Bursell, 2014), where applicants with a Swedish sounding name have a 50 percent higher probability to be called to interview compared to applicants with Arabic-sounding names (Attström, 2007). In a similar study (Carlsson & Rooth, 2007), the same phenomenon occurred, although not as severe. These researchers discovered that it took 15 applications from Middle Eastern applicants to achieve three callbacks, whilst only ten applications from Swedish applicants were needed to achieve the same number of callbacks (Carlsson & Rooth, 2007). Moreover, with respect to remuneration, changing one's name to a more Swedish-sounding surname has been positively correlated with a substantial increase in annual earnings (Arai & Skogman Thoursie, 2009). Similar inequalities are also well-documented within in

the education system (see, for instance, Dovemark, 2008, 2012; Lindgren, 2010). A study on grading found test results to differ between Swedish pupils and pupils with a foreign background, which was not the case when these tests were conducted as blind tests, thus a lack of consistency regarding assessment is a reasonable explanation for this discrepancy (Hinnerich, Höglin, & Johannesson, 2014). Furthermore, research has also detected the presence of ethnic discrimination in the housing market – Swedes were generally privileged in access to housing (Ahmed & Hammarstedt, 2008; Carlsson & Eriksson, 2012).

I have presented examples of gender and ethnic discrimination that exist in various sectors of Swedish society. In the next section, I examine discrimination in the context of health care, primarily in Sweden.

DISCRIMINATION IN HEALTH CARE

Previous research that has been undertaken regarding discrimination in health care shows that today's health care lacks equality with respect to gender, ethnicity, as well as other social positions. In Sweden, social differences in health were first paid attention to in a governing document in 1982, entitled *The Health and Medical Service Act* (Diaz, 2009). This act has subsequently been further emphasized through numerous state reports and additional governing documents. (See, for instance, Socialstyrelsen, 1987, 2004, 2005, 2006, 2009a, 2009b, 2011; Statens offentliga utredningar, 2000, 2006a).

Among the areas mentioned in Diaz (2009) is the difference between Swedish women and women who were born in Africa. It was discovered that African women received inadequate treatment, in terms of cancer screening when compared to the treatment provided to Swedish

women. Further, cancer screening is an intervention directed mainly towards privileged Swedish women. It was also noted that with respect to the treatment of cardiovascular diseases, members of the Swedish middle class received treatment to a much greater extent than the working class. To compound this situation, the interpersonal treatment of foreign-born patients was found to be substandard. A lack of quality communication was seen as the main factor in the creation of further injustices, such as the prescription of older and less effective drugs to foreign-born patients (Diaz, 2009).

Furthermore, The National Board of Health and Welfare (2004) have indicated that there exist deficiencies in sexually-segregated medical research projects. These deficiencies may lead to situations where women are treated on men's conditions and thereby may be the recipients of substandard or inappropriate care. It has been established that men are given better care, and that women and men are treated differently when they are present with the same symptoms (Smirthwaite, 2007). For example, Risberg (2004) and Risberg, Johansson and Hamberg (2009), have found that different forms of care are given to women and men although the symptoms are the same; at medical examinations, men are more thoroughly examined and undergo more tests than women, while women are offered medicine much earlier in the examination process. Socialstyrelsen (2004) and Sveriges Kommuner och Landsting (2014) have established that men are offered newer and more modern medicines than women, and that the cost per prescription is higher for men than for women. A study of individuals who have been ill for a long time (the chronically ill) shows that women, to a greater extent than men, feel poorly treated by the health care system (Upmark et al., 2007).

It has also been observed that women have longer waiting times for surgery than men (Smirthwaite, Lundström, Albrecht, & Swahnberg, 2013; Sveriges Kommuner och Landsting & Socialstyrelsen, 2012, 2013). In addition to the above, women have more sick-listed days than men. Smirthwaite (2007) suggests that possible reasons for this are the differences between the sexes regarding sickness and inadequate medical knowledge about women's health problems. For instance, regarding various kinds of cardiovascular ailments, it was shown that knowledge of how symptoms manifests themselves in women were substandard. Johannisson (1994) discusses how stereotyped views about women as 'the weaker sex' is still an existing view that continues to be reproduced from the time when women's diseases were diagnosed as 'hysteria' and 'weak nerves'[7]. Such thoughts are reflected in contemporary medical advertisement campaigns where men are portrayed in physically demanding jobs and women are presented as weak and passive (Socialstyrelsen, 2004). Since 2006, the Swedish Association of Local Authorities and Regions, together with The National Board of Health and Welfare, have conducted comparative research on all of the County Councils in Sweden (Öppna Jämförelser – Open Comparisons[8]), examining at a

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[7] Based on a very specific study, white upper class women in the late 1800's suffered from weak nerves, fatigue, and, to a great extent, lived their lives in bed (Johannisson, 1994).

[8] This national tracking system for health care results is mandatory for health care providers in Sweden and is one example of a measuring tool and model that is designed to increase efficiency; as advocated in the current discourse on New Public Management and its related performance paradigm.

large quantity indicators measuring health and health care delivery[9]. In the report of 2013, indicators that were linked to social positions were incorporated in a separate report with a specific orientation towards *equal care*. The report only covered two social positions (sex and age) (Socialstyrelsen, 2013). The majority of the indicators that were associated with the provision of equal care concern strictly medical results, and only a small number of the indicators refer to other important issues, such as patient experience, interpersonal treatment, and the provision of information (Socialstyrelsen, 2013). The report suggested that there are some differences between how men and women are treated. The differences were not based on participation; since 69 percent of both sexes answered that they felt involved in decisions that were made about their care and treatment. However, with respect to interpersonal treatment, 91 percent of the men and 88 percent of the women felt that they were treated with respect and in a considerate manner, and with respect to receiving information about their care, 75 percent of the men and 71 percent of the women felt that they received enough information about their condition.

In 2011, The Swedish Agency for Health and Care Services Analysis (Myndigheten för vårdanalys) was commissioned to analyze unjustified differences in the provision of Swedish health care. What the agency discovered was that there is a lack of data and research with respect to

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[9] There were 57 indicators in 2006, 75 in 2007, 101 in 2008, 124 in 2009, 134 in 2010, 173 in 2011, 169 in 2012, and in the latest study, from 2013, 162 indicators (Sveriges Kommuner och Landsting & Socialstyrelsen, 2006, 2007, 2008, 2009, 2010, 2011, 2012 and 2013).

protected social positions, such as ethnicity and gender reassign-
ment/sexual orientation. The same paucity of data and research on in-
terpersonal treatment was also found. Sex was the only protected social
position that was highlighted in the report (Myndigheten för vårdanalys,
2013a). I conclude that there exists a preference for qualitative studies
with a strictly clinical focus, and that social position often is overlooked,
at least when it comes to research performed by Government Agencies.
This is further underlined in the memorandum *Strategi för en god och mer
jämlik vård 2012-2016* (Strategy for good and more equal care 2012-
2016) (Regeringskansliet, 2012), which calls for increased awareness and
knowledge of what factors and issues that contribute to the existence of
inequalities in health care in terms of health care financing, organization
and implementation, leadership and governance, and tools and exper-
tise.

However, in contrast to the various Swedish agencies mentioned above,
the international research community offers us better insight into quali-
tative studies with respect to verbal interpersonal treatment and com-
munication. However, it is first important to clarify the fact that an un-
even power balance characterizes the communication between patients
and health care workers. For obvious reasons, this type of communica-
tion is influenced by a strong medical-driven agenda (Siouta, Broström,
& Hedberg, 2012; Siouta, Hedberg, Hedman, & Broström, 2012), which
influences the communicative conditions. The communication takes
place within an institutional discourse (Agar, 1985), and this discourse
dictates what can be said, by whom, and with what authority. Even
though patient-centred care (PCC) has been increasingly advocated as
an expression of quality care (Committee on Quality of Health care in

America, 2001; Socialstyrelsen, 2006), and (through the implementation of NPM) has been seen as a method for increasing efficiency (Jonsson, Agardh, & Brommels, 2006), patients still meet the health care workers in a disadvantaged state. They are not only sick, but also lack the knowledge and ability to cure the disease, while the health care worker is healthy and has both the knowledge and ability (in many cases) to cure the patient. These conditions may cause the patient to admire the health care worker (Vinthagen, 2007).

In previous research on communication, it has been suggested that gender and ethnicity have a major impact on the treatment of, and the communication with, patients in the health care context (Cooper et al., 2012; Dovidio et al., 2008; Ekstrand, 2010; Foss & Sundby, 2003; Lyratzopoulos et al., 2012; Shavers, Klein, & Fagan, 2012; Viswanath & Ackerson, 2011). Focusing on gender and communication, the ascription of gender-specific characteristics is evident. In terms of patients, women and men are assumed as being different from each other when it comes to communication (Andersson, Salander, Brandstetter-Hiltunen, Knutsson, & Hamberg, 2008; Salander & Hamberg, 2005); their attitude towards medical treatment (Ziefe & Schaar, 2011); and their perception of information (Dearborn et al., 2006). Such assumptions can, lead to clinical and health-related insufficiencies (Arber et al., 2006; Hamberg, 2008; Hamberg, Risberg, & Johansson, 2004; Risberg et al., 2009; Thornton et al., 2011). Thus, these gender stereotypes generate certain gendered characterizations, which construct the patients' identity, inter alia through communication.

Regarding ethnicity, previous research indicates that the health care industry in Sweden also suffers from a number of deficiencies (Diaz,

2009; Socialstyrelsen, 2011; Statens offentliga utredningar, 2006a). Groglopo (2006) observes that racism, everyday discrimination, and the experience of injustice and degrading treatment produce effects on the physical and mental health of the patient that supersede the effects associated with a patient's socio-economic conditions. Research on how stereotypical ethnic assumptions emerge and are reproduced within the health care education system have uncovered ample study materials that convey racist ideas. One example is the teaching materials on the topic of 'multicultural care' that create perceptions of immigrant patients as cultural objects who, it is claimed, lack the ability to understand the rationality of 'Swedish medical thinking' (Statens offentliga utredningar, 2006a). From an international perspective, previous research has shown that immigrant patients are exposed to substandard communication to a greater extent than local citizens (Abrums, 2004; Burgess et al., 2007; Johnson, Roter, Powe, & Cooper, 2004), and that this substandard communication tends to shift from being interpersonal to being clinical, thereby becoming the main cause of future inequalities (Szczepura et al., 2005). Moreover, ethnic minorities are also exposed to more verbal domination and less patient-centeredness in their interaction with health care providers (Johnson et al., 2004). Stereotypes and prejudices against ethnic minorities that are held by health care workers have also been linked to discrimination (Burgess et al., 2007; Dovidio et al., 2008; van Ryn & Fu, 2003). In Sweden, a national patient survey in primary care and hospital service showed that ethnic minorities felt they were less informed, less respected, and less involved in their care compared to Swedish patients, which consequently led to these ethnic minorities providing worse reviews of their treatment, information, and participation (Socialstyrelsen, 2011). There also exist studies that show a correlation

between perceived discrimination, on the on hand, and mental and physical illness, on the other, among ethnic minorities (Groglopo, 2006).

As for communication *about* patients with reference to different social positions, the previous research is sparse. Communication between health care workers has been the subject of numerous studies and the presence of substandard communication is well-documented. (See, for instance, Berry, 2006; Desme et al., 2013; Kripalani et al., 2007; O'Daniel & Rosenstein, 2008; Rovio-Johansson & Liff, 2012; Wauben et al., 2010). But these studies either focus on efficient information transfer or on conflicts within the group of health care workers. As Lingard et al. (2002) point out, a professional identity is formed by the communication among the health care workers, which ultimately affects the patients as well (Hewett, Watson, Gallois, Ward, & Leggett, 2009). Therefore, as a way to further our understanding of communication *with* patients in reference to social positions, it is also important to investigate communication *about* them.

Equal care, as demanded for in the governing documents referred to above, has not yet been achieved; neither with respect to gender, nor with respect to ethnicity. However, the provision of equal care is only one of several demands. Health care system must attend to all of them, even though efforts to fulfil one demand may compete with efforts to fulfil another. The Swedish health care system also faces challenges in terms of inadequate funding for meeting the needs of a growing and aging population, thereby necessitating organizational changes that use available resources more efficiently. Such changes will impact on how an organization is able to meet the equality demand. The following section takes a look at some of these challenges.

A CHALLENGE TO THE PROVISION OF NON-DISCRIMINATORY AND EQUAL CARE

As seen in the previous section, the National Board of Health and Welfare and the Swedish Association of Local Authorities and Regions use a number of indicators for measuring the delivery of Swedish health care. These indicators, to some degree, refer to the demand for equality, but also to other demands (such as safety, knowledge-based, patient-centred, efficiency, and timely). The indicators show that the demands that are expressed in the *Quality Care* document (and other documents) are not fully met (Sveriges Kommuner och Landsting & Socialstyrelsen, 2006, 2007, 2008, 2009, 2010, 2011, 2012 & 2013). Thus, the health care system does not fulfil its potential. Note too that it is only under certain circumstances, or only infrequently, that optimal care is provided (Nelson et al., 2007). Brommels (2006) identifies a number of critical gaps and failings in the delivery of health care in Sweden, such as between knowledge and practice; between different levels and professional groups in multi-professional organizations; between intended- and received quality; as well as between best available practices and real outcomes. The Swedish National Audit Office found that regulatory acts are inadequately implemented – with inferior support given to the executive authorities by the government and national authorities (Riksrevisionen, 2004). The government has not been able to create the necessary conditions to facilitate that these health care priorities in are fully respected. Governance has mainly been accomplished by changes and additions to the regulatory acts, at the expense of following-up on these alterations.

Besides the gaps mentioned above (i.e. between knowledge and practice, different organizational levels and professional groups, intended- and received quality, and between best available practices and real outcomes) and inadequate governance, Berwick, Nolan and Whittington (2008) see the shortcomings in health care as a result of a complex assembly of economical, practical, environmental, systematic, political, and human deficiencies that prevent the health care system from fulfilling its potential. The consequences of these gaps concern the patients (of course), and the societal economic costs as well, due, for example, to the delivery of inadequate treatments (McLaughlin & Kaluzny, 2005). The economic incentives for accomplishing health care improvement and to meet quality demands are intensified by the fact that the revenues given to the Swedish County Councils, in the form of tax and government grants, have decreased in recent years (Anell et al., 2012; Falk & Nilsson, 1999). Ackerby et al (2005) predict that, after the year 2015, due to a decrease in the tax base (which is a result of demographic development with an apparent growth in the population of people who are over 80 years of age) the health care-related economy will be in deficit in Sweden. This trend is the same in most western countries (Fox & Kongstvedt, 2013). The medical and technological development in the field[10] will also add to that deficit by approximately 0,8% per year (Ackerby et al 2005). This figure is calculated after deducting the benefits that come from the developments, such as lower cost per treatment or intervention, whilst new groups become eligible for treatment. As a result of financial scar-

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[10] Ackerby et al, 2005, provides us with a fairly broad definition of medical and technological development, including more effective drugs, improved surgical techniques, as well as organizational changes such as reorganizations.

city, there have been increasing demands on the effectiveness of health care, which, among other things, the principle of efficiency is a sign of.

> Several recent initiatives and many under discussion are guided by an emerging performance paradigm in the governance and management of health care. Key words related to the current and expected future trend are national quality registers, public comparison of quality and efficiency across local authorities and providers, value for money invested in health care, health outcomes and benefits from the patient perspective, process orientation and coordinated services. (Anell et al., 2012, p. 104).

Thus, a major challenge to non-discriminatory and equal care is economic scarcity, which tends to give other demands preference, primarily the demand for efficiency. In the next section, I will take a look at efforts that have been (and are being) implemented in the Swedish health care system which have the ambition to meet other demands as well.

THE CURRENT SOLUTION – NEW PUBLIC MANAGEMENT

When the gap between needs and resources increases, the need for health care improvement or a new performance paradigm intensifies. Historically, different solutions have been advocated for during different epochs. Until the 1980s, a rather egalitarian point of departure was adopted in the Swedish health care system, whereby solutions such as the reallocation of resources were implemented. The past decade, however, has seen an increasingly stronger neoliberal point of departure,

which has advocated for solutions that highlight freedom of choice (for instance, between private and public caregivers). It is claimed that individuals themselves know best what they need and that their willingness to pay is an important measure of this (Burström, 2011). Berwick, Nolan and Whittington (2008) suggest a "triple aim" which entails (i) improving the individual's experience of care, (ii) improving the health of populations, and, at the same time, (iii) reducing the per capita costs of care. In order to facilitate this triple aim, certain obstacles need to be overcome:

> Supply-driven demand; new technologies including many with limited impact on outcomes; physician-centric care; little or no foreign competition to spur domestic change, as it does in manufacturing; and too little appreciation of system knowledge among clinicians and organizations, leading them to sub optimize the components of the system with which they are most familiar, at the expense of the whole. (Berwick et al., 2008, p. 761)

Health care needs to introduce measurements that are transparent, and to carry out public health interventions a larger extent than it does at the present. Furthermore, patient-centered care (PCC) becomes important as patient centeredness and involvement is expected to improve and increase efficiency (Bertakis & Azari, 2010; Miracle, 2011). To meet the demands of PCC, it is important to constantly organize the design of the care and to coordinate the care at the patient level, and to ensure a universal access to care. At the same time, as durable financial management system needs to be implemented.

A strong advocacy for PCC also demands changes and adjustments. Along with an emerging belief in collaboration in general, which replaces traditional bureaucratic governance with various models of interaction (Falk & Nilsson, 1999; Hasselblad et al., 2008; McLaughlin & Kaluzny, 2005; Målqvist et al., 2011; Rovio-Johansson & Liff, 2012), as seen in, for instance, the operation of the Clinical Microsystem (CM) (Hedegaard & Ahl, 2013 – Paper IV in this thesis), the health care system takes on a certain level of complexity, since the views of the public, the views of the individual patient, and the views of the patient's relatives are taken into consideration to a much larger extent than before. At the same time, evidence-based and expert-driven approaches to care remain as guarantors for the provision of high quality care (Socialstyrelsen, 2006, 2009a; Svensk författningssamling, 1982).

Thus, the Swedish health care system faces major challenges. Brommels (2006) even goes so far as to call it a crisis, with huge gaps between the potential of the medical field and the actual conditions that exist in the health care system. In order to bridge these gaps and to enable progress and improvement, there is a need for new knowledge, a deeper understanding of the systems, and learning processes which generate high quality care and systematic improvement. This task cannot be undertaken from a strictly medical perspective; instead, there is a need to look beyond the traditional medical research field (multi-disciplinarily), and focus on the health care organizations, and their ability to translate knowledge into practical action within these organizations (Berwick et al., 2008; Calltorp, Johansson, & Maathz, 2006). This transformation, or *extension* of the medical paradigm, is well on its way in many Swedish County Councils who have already implemented a number of changes

that are inspired by ideas with a none-medical origin. These Councils have primarily used different models and control systems taken from the business community (Henriks & Berger, 2007), but also from the engineering sector (Nelson et al., 2007), and high-reliability industries, such as the nuclear power industry and various types of space programs (Leonard et al., 2004). What many of these interventions have in common is that they are a part of the New Public Management (NPM) discourse (Hood, 1991, 1995), which gives it a more market- and customer-oriented view on the health care system (Falk & Nilsson, 1999; Hallin & Siverbo, 2003), with a strong emphasis on quality improvement (Lagrosen & Lagrosen, 2009). These types of intervention rarely come separately and independently; instead, they originate from *a greater system of beliefs* – beliefs that are not necessarily the same as the laws and legislations that govern them are based upon.

The emphasis on the importance of the market and the customer implies a shift in focus, from highlighting the care-giver to centre on the care-taker instead. In addition to this shift in focus, there have also been a number of changes[11] in the Swedish law which strengthen the patients' rights. This shift can be observed on the international scene as well. According to Cahill (1998), patient participation in health care is "emerging as a growing movement wherein patients are assuming more responsi-

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[11] On January 1, 1999, The Health and Medical Service Act, The Health care Profession Act, and The Patient Commission Operation Act (Lagen om patientnämndsverksamhet) were changed and given a more explicit patient-centered point of departure, with focus on information, participation, and influence (Socialstyrelsen, 2003).

bility for the prevention, detection and treatment of health problems in a manner that supplements or substitutes for professional services" (p. 119). Before the advent of patient-centered care, the patient was perceived as a passive recipient of care, and decisions concerning the patient and the patient's health were reserved for the physician, whilst the patients often were kept uninformed of their health situation (Cahill, 1998). But earlier views of patients as being ignorant have now been replaced by the view where patients are seen as more knowledgeable (for example, they are seen to be better educated and more aware of their rights), and therefore deserve to be, and are better suited to be, involved in their own treatment to a far greater extent than previously, and, to some extent, patients are considered to be responsible for their own health (Committee on Quality of Health care in America, 2001; Miracle, 2011; Sidani, 2008). Patients are included in a "society of knowledge", in which citizens are expected to make their own choices, be well-informed, and highly involved [12], [13] (Ellström, Gustavsson, & Larsson, 1996; Nordgren, 2003).

According to Lagrosen and Lagrosen (2009), the emphasis on quality improvement constitutes a foundation that is composed of a set of val-

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[12] The consequences of increased patient responsibility in relation to ethnicity and PCC are further discussed in paper II – *Communicative construction of native versus non-native Swedish speaking patients in consultation settings.*

[13] This is expressed, inter alia, by the replacement of the "outdated" word *patient* with new, more modern, and suitable terms like *co-creator* and *co-producer of care* (Nordgren, 2003), exemplified in the research project 'Bridging the Gaps II'.

ues that is shared by organizations applying these ideas. The first value, *customer orientation*, implies a commercial outlook on the organization, as well as an understanding of the co-workers as being service providers first and foremost. The second value, *engaged leadership*, informs management that management is expected to be inspired by the quality development work, and have that as their top priority. The third value is *participation*, which emanates from the view that the co-workers are suitable agents to contribute to quality development, as they have the most profound insight into their own working conditions. With respect to this value, the assumption is that the co-workers want to contribute, and that it is strategically favourable to fulfil their wishes, and thereby create co-workers who are satisfied with their work, as well as with their management. The forth value is *process orientation*, which creates conditions where the concept of result is replaced the concept of process; for example, a satisfied customer (in this case a patient) becomes the process, instead of the goal. The fifth value is *constant improvement*, which implies a reduction of the errors made in the organization, but also continuous improvement of areas that already work but, nevertheless, are expected to be even further developed. The sixth and final value is *fact-based decision making*. It is closely related to the evidence-based discourse, which is strongly related to health care discipline. This value introduces the organization to measuring tools and models that, taken together, offer a statistical basis from which decisions can be made.

Thus, the parts that contribute to the extension of the medical paradigm within health care, which is mostly influenced by NPM, have brought large-scale organizational changes that affect the view of the patient as well as the role of the health care worker. Moreover, NPM can be un-

derstood as consisting of interests that are not necessarily compatible with the demand for equal care, such as standardization and rationalization of common activities (Donaldson & Mohr, 2001). Nevertheless, NPM is now incorporated in the governing documents and the regulatory acts, just as the demand for equality is. Consequently, they all operate in parallel and influence the health care organization jointly (Bevan, Helderman, & Wilsford, 2010). This chapter has highlighted the predominate influences and discourses that affect the organizational and institutional culture and conditions wherein the equality and/or lack of equality (read *discrimination*) must be understood.

SUMMARY AND GAPS IN PREVIOUS RESEARCH

What the above discussion claims is that gender and ethnic discrimination is common, and that it affects both how women, men, and foreign individuals are perceived, as well as how they are treated in health care system. So far, previous research on communication that creates disadvantages, exclusion, and ultimately discrimination in health care, has been fragmented. First, the participating parties in the communication process have been separated from each other, and, more often than not, the research interest has been directed merely towards the health care workers. Extant research has included the health care workers' unconscious assumptions (see, for instance, Burgess et al., 2007; Cooper et al., 2012; Dovidio et al., 2008; van Ryn & Fu, 2003), and their attitudes (e.g. Arvaniti et al., 2008; Street, Gordon, & Haidet, 2007), whereas the verbal interpersonal contribution of the patient often is overlooked. Therefore, it is important to examine both the patients' and the health care workers' contributions to the communication that takes place. Second, due to the virtually non-existent research on communication *about* pa-

tients in reference to their social positions, an important part of the communicative process in health care has thereby been overlooked. Third, the communication has often been separated from the context within which it takes place (Ackerson & Viswanath, 2009). Linked to this, health care is subject to other demands besides the demand for equality. In the operationalization of these other demands, an additional system of beliefs appears in the form of NPM, which influences the conditions for effectuating the equality demand in different ways. Therefore, it becomes important to also pay attention to the organizational and institutional context and discourse of health care, in order to avoid this separation, and, instead, contribute to knowledge based on the complexity that interpersonal and organizational communication demands.

THEORETICAL AND CONCEPTUAL FRAMEWORK

In this chapter, I give a presentation of the overall theoretical perspective and approach that is used in this thesis. In light of this, I will also further explore the key concept of 'discrimination' and highlight the other central concepts that have been used in this thesis.

A SOCIAL CONSTRUCTIONIST FRAMEWORK

Although the theoretical point of departure that I have employed in my research is explicitly detailed in only one of the four papers in this thesis; however, they all rest on a social constructionist foundation (Berger & Luckmann, 1966; Burr, 2003; Weedon, 1999). This entails certain epistemological implications which run counter to health care's predominant positivistic epistemology, which is characterized by an ambition for robust and value-free knowledge (Sweeney & Kernick, 2001). This anti-essentialism that social constructionism shares with post-modernism and post-structuralism opposes the notion that categories (for instance, social positions such as gender and ethnicity) are constituted by an essential nature that gives the categories their identity (Gelman, 2003; Grillo, 1995). The central premise of social constructionism is that knowledge is an interactive construction (Berger & Luckmann, 1966), and that our understandings (of, for instance, 'gender' and 'ethnicity') emerge from us adapting to the socially-shared representations of the world that we accept as reality. This, in turn, implies that different social and cultural backgrounds, values, orders, and norms influence, and to some extent, limit our thoughts, feelings, and behaviour (Burr, 2003).

Different social and cultural backgrounds, values, orders and norms, together with stereotypes and prejudices, constitute a form of cognitive essentialism (Sayer, 1997). This means that, in order to make sense of reality, individuals do, and must, simplify things through various kind of categorizations that are used by the discriminating as well as the discriminated – patients as well as health care workers. One's point of view and one's understanding of the social world, including the understanding of one's self, is conditioned by one's social location and experience thereof (Freire, 1972). The social world and the linguistic contexts that humans are born into contain pre-designed categories that limit our understanding of the surrounding world. When people design their identity there is a limited amount of linguistic categories that they must conform to, and thus the individual learns to see itself and its environment on the basis of the prevailing cultural order and conforms to the categories found therein (Berger & Luckmann, 1966; Burr, 2003).

This social constructionist framework has implications for the central concepts that are used in this thesis. Below, I will elucidate these concepts in order to clarify how they are understood in this thesis.

UNDERSTANDING DISCRIMINATION AND EVALUATIVE IDEAS

The key concept of the thesis, 'discrimination', was described as a common practice in the introduction chapter (Abrams, 2010; Illeris, 2001; Johnsdotter, 2007; Schneider, 2004). In the Chapter 2, it was established that it is 'evaluative discrimination' that is being explored in this thesis, and that stereotypes and prejudices are seen as a non-explicit or merely a cognitive version of explicit and action-oriented discrimination

(Fredman, 2011; Heckman, 1996; Svensk författningssamling, 2008; Whitley & Kite, 2010). In this section, discrimination, stereotypes, and prejudices will be further explained in order to increase the understanding of how they are considered throughout this thesis.

My point of departure is based on the claim that no particular group or set of individuals are especially prone to act in a discriminatory way or to harbour stereotypical and prejudicial assumptions (non-democratic movements being potential exceptions here of course). According to Schneider (2004) and Bodensteiner (2007), *we all* use stereotypes in order to make subjectively "informed" judgments regarding ourselves, as well as others, thereby making life more predictable and manageable. Illeris (2001) claims that we are more likely to reinterpret information so that it is consistent with our prior understanding, than to change our mindset, even though the information might be of such a sort and content that change would be required. Thus, with respect to information, the process of assimilation is more often used than the process of accommodation. Moreover, stereotypes are transmitted and reproduced through communication and language; by the words and phrases that we often use without reflection, (Kite & Whitley, 2012; von Hippel, Wiryakusuma, Bowden, & Shochet, 2011). For instance, when referring to people in perceived non-traditional roles, their alignment to certain social position(s) becomes highlighted (Ng, 2007); for example, "male nurse", "female physician", "tearful male patient", and "non-native Swedish speaking patient". These labels highlight the stereotypical and prejudiced assumptions from a sender- and receiver perspective, where the two parties are different individuals and/or groups. However, the individual and/or group may also harbour stereotypical assumptions about them-

selves (Ridgeway & Correll, 2004) as a result of being exposed to cultural norms, in which the value of an individual is linked to his/her alignment to certain social positions (Freire, 1972).

Stereotypes and prejudices are more than mere cognitive constructions (Roets & van Hiel, 2011). Even though they may be displayed by individuals, their emergence lies elsewhere. Prejudice can be viewed as "a process within a set of relationships, rather than a state or characteristic of particular people" (Abrams, 2010, p. 8). Prejudices in the form of stereotypes are more likely to appear when groups have different or conflicting key values; others are seen as different, while people see their identity in terms of belonging to particular groups, and, of course, whether a group discriminates against another group (Abrams, 2010). At the collective level, communities are created, reinforced, and preserved by the enactment of contrasts with other communities (Hylland Eriksen, 1995). The residents of the different communities are ascribed with contrasting characteristics by which they are constructed as each other's counterparts. Thus, any definition of how *we* are also contains an implicit definition of how *the others* are (de los Reyes & Kamali, 2005a). Moreover, from a historical perspective, the ideas of doing away with discrimination and celebrating equality are quite modern (Fredman, 2011). In summary, there exist individual cognitive challenges as well as collective and historical challenges to overcome in order to undermine the force of stereotypes, prejudices, and discrimination.

So far, the focus of my discussion has been on the thoughts, feelings, and assumptions that are harboured by those who subject others to discrimination. Turning to the people who are subjected to and affected by discrimination, we may ask ourselves whether discrimination is per-

ceived or 'actual'. This distinction has been the subject of many studies with varying results, particularly within the field of health care. There have been studies where the presence of discrimination (or at least the consequences of discrimination) has been questioned due to a lack of correlation with the quality of care received (Benkert, Peters, Clark, & Keves-Foster, 2006; Sorkin, Ngo-Metzger, & De Alba, 2010). Others dismiss perceived discrimination on the grounds that the perception is formed by a general distrust of the health care system rather than on any personal experiences (Hausmann, Kressin, Hanusa, & Ibrahim, 2010; Kandula, Hasnain-Wynia, Thompson, Brown, & Baker, 2009). There are, however, studies that highlight perceived discrimination as an important indicator of the state of the health care system. People who are used to being discriminated against in other contexts, are usually those who also feel discriminated against in the health care context (Gil-González, Vives-Cases, Borrell, Agudelo-Suárez, & Álvarez-Dardet, 2013; Kandula et al., 2009). It is, therefore, impossible to achieve equal care until discrimination in society as a whole, as well as in the health care system, is confronted and dealt with (Wamala, Merlo, Boström, & Hogstedt, 2007). In contrast to researchers who dismiss perceived discrimination, several other studies have found a strong connection between perceived discrimination, on the on hand, and clinical- and health-related inadequacies, on the other (Burgess, Ding, Hargreaves, van Ryn, & Phelan, 2008; Lee, Ayers, & Kronenfeld, 2009; Pascoe & Smart Richman, 2009). The presence of discrimination, the consequences of being subjected to it, and how specific social positions are particularly affected may be understood by carefully re-examining the discrimination and equality acts. In these acts, there are a number of social positions that are specifically safeguarded. These include people

who are considered to possess characteristics that are particularly affected and thereby in need of special protection. The most common protected social positions are sex, gender reassignment, ethnicity, religion or belief, disability, sexual orientation, and age (Parliament of the United Kingdom, 2010; Svensk författningssamling, 2008). The UK is more generous in its formulation of the Equality Act when compared to the Swedish Discrimination Act, since it includes reference to 'marriage and civil partnership', where 'civil partnership' is equated with 'marriage'.

Stereotypes and prejudices are linked to discrimination; the former are a prerequisite for the latter. Stereotypes and prejudices need not automatically lead to discrimination, but when they are expressed, either verbally or in writing, I regard them as discrimination. One can distinguish between discrimination and discriminatory behaviour, where the latter represents a kind of intermediary between stereotypes and prejudices, on the one hand, and discrimination, on the other hand. This is, however, not something that is being investigated to any significant extent within the research community. Discrimination and discriminatory behaviour are, instead, for the most part, considered as synonyms. Even though I have no ambition to determine whether a specific behaviour and/or communicative treatment are expressions of discrimination in a legal sense, I choose to consider all verbally expressed, explicit and action-oriented activities as discrimination.

SOCIAL POSITION

Discrimination is seen (and understood throughout this thesis) to be present at the intersection between (i) the limitations to construct iden-

tity/identities and (ii) the predominant institutionalized discourse that influences the context and the organizational culture in the health care system. So far, I have discussed discrimination that may be directed towards an individual on grounds of two social positions, gender and ethnicity. But what is a 'social position'? In the concept, lies a distancing from a deterministic and essentialist standpoint, in that social positions are socially and linguistically constructed, and that the "core of what is human" cannot be reduced to an individual's alignment with one or several social positions (de los Reyes et al., 2006). Instead, a 'social position' is characterized by multiple expressions and boundary crossings (Butler, 2007; Connell, 1995).

What then, constitutes a social position? In a broad sense, the concept *social position* includes all the different positions that contribute to social stratification and influence the way in which others perceive a person. These positions include such things a person's education, occupation, income, but also other aspects such as age, sexual preferences, gender, and ethnicity (Lindemann, 2007). Among these different social positions, gender, race, and class attract the most attention from research, both separately but also together (Crenshaw, 1989; Knudsen, 2006; Lykke, 2005). A recurring and central issue within gender theory and research is the relation of different social positions to each other. Other questions that are addressed in gender research are whether the advantages and disadvantages that are associated with the various positions should be analyzed individually or whether it is more fruitful to analyze them together. An example would be a study on how a person is discriminated on the grounds of sex and ethnicity simultaneously, and how these positions intersect, possibly reinforcing each other. McCall (2005)

has identified three research approaches that frequently consider individuals' and groups' alignment to multiple social positions in different ways. First, the anticategorical complexity approach, where the deconstruction of categories is the ambition of the researcher. Second, the intercategorical complexity approach, in which analytical categories (or social positions) are used in order to pay attention to inequalities, which are often accompanied with an alignment to the categories/social positions. Finally, the third approach is the intracategorical complexity approach, which represents an understanding that is equidistant from the two previous approaches. This approach questions the foundations on which the category-making and category-defining processes rest, but at the same time, it acknowledges the stability and durability that social positions may represent and the reproduction of injustices that this might entail (McCall, 2005). In summary, social positions are socially constructed and therefore always in flux, but are, amazingly, persistent and difficult to change.

To understand and explore discrimination that is linked to different social positions, my ambition is to reveal how the particular social positions are constructed. In light of this, intracategorical complexity (McCall, 2005) serves as the approach through which social positions are understood throughout this thesis. I recognize that categorizations provide us with a simplified view of an individual or a group and I recognize the limitations that this entails, but, such a view is impossible to avoid. Chancer and Xaviera Watkins (2006) emphasize that there are both similarities and differences in discrimination directed to different social positions. The similarities are (i) the shared experiences of being discriminated, and (ii) discrimination as characterized by stereotypes and prejudices of disparaging features. The differences are the different

stereotypes and prejudices that are directed towards the different social positions. Consequently, I analyze the two prominent social positions of gender and ethnicity individually.

In accordance with the discussion regarding cognitive essentialism (Sayer, 1997), the opportunities to express various social positions in a boundary-crossing manner are by no means limitless (other than in theory). With that being said, this does not entail that social positions are determined by fixed structures either. Available discourses are limited in their range due to values, orders and norms, and stereotypes and prejudices. It is also the case that certain discourses are more easily drawn on under certain circumstances (which tends to repeat itself and thereby contribute to discrimination). Thus, in alignment with social constructionism, I consider the various social positions to be social constructions, but, as Burman (2003) points out, different social positions tend to have different norm-bearing discourses attached to them, which may lead to discrimination for individuals/groups who are aligned to these social positions.

GENDER

As one of the two prominent social positions that is studied in this thesis, gender refers to the culturally and socially constructed differences between individuals that is based on their biological sex (Nicholson, 1995; Oakley, 1972). This implies that the way in which we consider women and men, femininity and masculinity, is influenced by preconceived and unconscious stereotypes and assumptions. These assumptions, in turn, influence how we identify specific characteristics and relate them to femininity and masculinity (Eagly, 2009), and how we subsequently respond and act

differently towards women and men. Thus, in this understanding, gender (femininity and masculinity) is something that is performed (De Beauvoir, 1997; West & Zimmerman, 1987). Theoretically, the possibilities to construct and develop gender identities are multiple when femininity and masculinity are considered as positions on a single continuum instead of being dichotomies (Butler, 2004). However, just as with discrimination that is associated with other social positions, the process of 'doing gender' is not a phenomenon that is merely produced by individuals (Butler, 2004; Eagly, 2009; West & Zimmerman, 1987). Apparent limitations present themselves in the form of various socially standardizing practices such as legislation, cultural structures and arrangements, as well as norms. West and Zimmerman (1987) explain this interaction by defining gender as an *"emergent feature of social situations: both as an outcome of and a rationale for various social arrangements and as a means of legitimating one of the most fundamental divisions of society"* (p. 126).

The previously-mentioned separation of the sexes (Acker, 1992), or the Gender Difference Model (Hyde, 2005), represents obvious obstacles for an individual's opportunity to express diverse or different forms of femininity and/or masculinity. As a social institution, gender is a predictable way to organize the division of labour, assign responsibility for children and others who cannot care for themselves, common values and the systematic transmission of these values to new members, including legitimate leadership, music, art, stories and other symbolic productions (Lorber, 1995). Ore (2005) presents a similar argument and sees this process of separating the sexes and invoking differences between them as taking place in three different contexts: the institutional context (family, education, the economy, the state and the media), the interper-

sonal context (interaction with others where we tend to rely on common guidelines for behaviour, such as norms), and the internal context (internalizing values mediated through the two other contexts). Thus, gender is socially, discursively, and contextually staged and brings structural inequalities to the fore (Seguino, 2007), and, thereby, also discrimination.

ETHNICITY

The second prominent social position that is of interest in this thesis is ethnicity. There is a plethora of concepts that, in different ways, relate to ethnicity. Groglopo (2006) mentions 'race' and 'culture', along with 'ethnicity', as concepts that have been used to create differences between people in different eras who are considered to be familiar and those who are considered to be strangers. In paper II – *Communicative construction of native versus non-native Swedish speaking patients in consultation settings* – the term *none-native Swedish speaking* was used to distinguish a certain patient group from another[14]. I do however, choose to use to term *ethnicity* in this thesis on the ground of its widespread use and its relational construction (Hylland Eriksen, 1993), thus distancing it from the more biological term *race*. I understand 'ethnicity' in the same way as 'gender', as socially constructed (Acker, 2006; Jenkins, 1997) through

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[14] This term was used at the request of the reviewers who reviewed the article. They did not explicitly advocate the term *non-native Swedish speaking patients* but they opposed the original term *ethnicity* and, in the empirical context, the more practical term *foreign-born patients*, on the basis that they considered the usage of these terms entailed a potential exaggeration of the similarities between the patients that were categorized as foreign-born.

communication and actions (Hylland Eriksen, 1993). Thereby, in alignment with McCall's (2005) intracategorical complexity, I acknowledge both the constructive features of 'ethnicity' in terms of the creation of privileges and domination on the one hand, and subordination on the other hand. At the same time, as I see this lack of equality as an expression of a continuously reproduced social practice (de los Reyes & Kamali, 2005a). Moreover, I consider the relational aspects of the concept as two-sided. First, it refers to the constructive features wherein ethnicity is staged (through communication in this case). Second, it also invokes the distinction between ethnicity and its contrasted part (Swedishness/Swedish as native language in this case).

COMMUNICATION

The social construction of gender and ethnicity have implications for communication, including its form and its content. Through language, we give meaning to and make sense of our world; including making sense of gender and ethnicity. In this sense, we also construct the world around us through language and communication (Berger & Luckmann, 1966; Burr, 2003; Fairclough, 2001; Linell, 2009) via discourses. Discourses are both constituting and constituted. Fairclough's (2001) three discourse dimensions are useful in order to explain the relationship between the constituting and constituted aspects of discourse and communication. Fairclough's dimensions include (i) *text* (a spoken or written communicative act), (ii) *discursive practice* (the production and consumption of a spoken or written communicative act), (iii) and *social-cultural practice* (the production and consumption of a spoken or written communicative act within the context of a practice, for instance an organization). These three dimensions may correspond to a specific statement

from a health care worker within a consultation setting in an organization inspired by NPM. The communicative content becomes of interest, not only for what it represents as a spoken communicative act (for instance, via the revelation of stereotypical and prejudiced assumptions linked to gender and ethnicity), but also how these representations, in social practice, influence the communication in return (for instance, by generating self-fulfilling prophecies, or resistance). Because of their constituting features, discourses possess the potential for transformation and change (Foster & Bochner, 2008). We can challenge the discourses that tend to diminish us, for instance, by taking upon ourselves the role of a counter-stereotypical actor (Phelan & Rudman, 2010), and there are always opposing discourses that confront other predominating discourses: "There are weak points, places where they may be attacked, and points at which other discourses pose a real threat" (Burr, 2003, p. 110).

In the light of the above, communication becomes the expression of specific discourses, instead of individual and isolated statements. Thus, a statement, as a constructive feature in a communicative setting, is linked both to previous and future statements as a form of social action that shapes social reality in constant social and linguistic interaction and knowledge (Linell, 2009), for instance, in terms of stereotypes and prejudices linked to social positions. This implies that interpersonal verbal communication is dialogic, or at least that it has the potential to be dialogic depending on how it is carried out. Its opposite is monologic communication, and a division between these two types of understanding communication is commonly done (See, for instance Linell, 2009; Stewart, Zediker, & Black, 2004). Dialogic communication also includes dialogic conceptions of understandings, meaning opposite points of

view can meet, both of which can be inter- and intrapersonal (Stewart et al., 2004). This means, for instance that harboured stereotypes and prejudices may be verbally expressed both as an unambiguous opinion, but also as an expression of an unconscious assumption (which is not necessarily an unambiguous opinion). Both opinions and assumptions can be met by argumentative- as well as acknowledging statements.

ORGANIZATION

I have discussed gender and ethnicity, and how they are related to discrimination. I have also discussed communication and how communication can be used to direct discrimination. In this section, I will investigate the organizational and institutional context in which we find discrimination. In the previous chapter, I discussed the health care organization from the perspectives of discrimination, equality, legislation, and challenging demands that compete with the demand for equality. Below, I discuss 'organization' as a concept in relation to discrimination and communication.

In alignment with social constructionism, I regard an organization as simultaneously constructed or produced by individuals and by collectives (Berger & Luckmann, 1966; Downing, 2005). However, within the organization, certain discourses (such as the demand for equality demand and NPM) are active and influence these organizational constructors. To apply Mayr's (2008) concepts, we note that an institution (health care) is shaped by discourses, which exert influence on institutional practices, for example, the institutional communication. As Agar (1985) stresses, an institutional discourse dictates the supply of discourses that are available in an organization, and further highlights sev-

eral of the challenges that health care faces. The challenges include demands for efficiency and time pressure, as examples of "circumstances around the institutional discourse over which neither the institutional representative nor the client have any control" (Agar 1985, p. 157). Accordingly, I consider organizations as knowledge and meaning generating entities (Campbell, 2000), in which discourses offer ideas, representations, understandings, ideals and so on, that produce a particular version of understanding regarding knowledge and meaning (Burr, 2003). In terms of health care, NPM represents a discourse that facilitates ideas and actions of standardization, measurements, streamlining, and rationalization, while it is less conducive to critical approaches that question the predominant discourse.

METHODOLOGY

In this chapter, I present the methodology that was used in the four pa- pers. It is primarily the three empirical studies (Papers I, II, and III) that will be highlighted, since Paper IV is a conceptual paper. First, a short overview is presented, which is followed by descriptions of the local contexts in which the empirical studies were conducted. Thereafter, the participants will be presented; first the health care workers, and then the patients. In the subsequent sections, the data-collecting methods, and the analytical frameworks and procedures are introduced. After these sections, the methodological discussion follows. The final section consists of a discussion of the ethical considerations that were made in the three empirical studies.

OVERVIEW

This thesis is based on data from consultations where communication between health care workers and patients took place (Papers I and II), observations of communication about patients during ward rounds and verbal handovers (Paper III), and a critical literature study on gender implications of the NPM-inspired management model, CM (Paper IV). Together, these studies revealed, in various ways, how discrimination is expressed in interpersonal and organizational communication within health care practices.

	Paper I	Paper II	Paper III	Paper IV
Focus	Communicative constructions of patient from a gender perspective	Communicative constructions of NS and NNS in reference to PCC	Communication about patients in multi-professional settings	CM from a gender and multi-professional perspective
Design	Interpretative qualitative study	Interpretative qualitative study	Interpretative qualitative study	Critical literature study
Datacollection	23 recorded consultations (nurses, physicians and patients)	11 recorded consultations (physicians and patients)	30 recorded verbal handovers and ward rounds	
Analytical framework	CDA	CDA and dialogic analysis	Qualitative content analysis	Gender analysis

CDA = Critical discourse analysis
NS = Native Swedish speaking patients
NNS = Non-native Swedish speaking
patients PCC = Patient-centered care
CM = Clinical Microsystem
Table 2. Overview on the research focus, design, data-collecting methods, and data analysis.

THE LOCAL CONTEXTS

The organizational context of health care was examined in previous chapters, but what remains is for me to provide a description of the local contexts in which the empirical studies were conducted. Regarding the studies on communication *with* patients during consultations (Paper I – *Gendered communicative construction of patients in consultation settings*, and Paper II – *Communicative construction of native versus non-native Swedish speaking patients in consultation settings*), the studies were conducted at six strategically selected hospitals (Hedberg, Johanson, & Cederborg, 2008) (one university hospital and five county hospitals) in southern Sweden, all of which had nurse-based outpatient clinics for patients with atrial

fibrillation (AF)[15]. The data that was used in these two papers was originally collected for other studies (Siouta, Broström et al., 2012; Siouta, Hedberg et al., 2012). These studies examined the variation in the topics that were discussed in the consultations. Sample variation was therefore originally prioritized, and was based on the clinics' location, size, and the number of AF patients treated. Due to the variations in these clinics, cardiology-related activity varied greatly between the university hospital (which had a large catchment), and the smaller county hospitals (which had a smaller catchment). A common characteristic of these clinics (regardless of their size and activity level) was that the nurses and cardiolo- gist met with the patients three months after their AF diagnosis. The nurses perform and document electrocardiographic monitoring, docu- ment the effects of cardioversion, and control the patients' dosage of medicine. The cardiologist takes over in the event that the patients need further counselling and support.

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[15] AF is an irregular and rapid heart rhythm caused by abnormal electrical im- pulses in the heart. Approximately 85% of patients who suffer from AF are older than 65 years. Symptoms include heart palpitations, lack of energy, dizzi- ness, chest discomfort, and shortness of breath. AF impairs the cardiac pump function and increases the risk of stroke for instance. Usual treatments are Wafarin, anticoagulants and cardioversion in persistent cases (Kotowycz et al., 2011).

For Paper III (*Communication about patients in multi-professional teams: A gender perspective*), the data was collected at a cardiac clinic at a hospital in southern Sweden. The cardiac clinic treats all types of heart disease, such as angina, myocardial infarction, heart failure, valvular disorder, arrhythmias, and AF. The observed settings were ward rounds and verbal handovers. They were selected through sample participant observations (Bernard, 2012), by which appropriate settings were chosen based on their ability to offer the expected, organized, and professional communication about patients between health care workers. The practical circumstances between the two settings differed even though both of them contained communication *about* patients. The verbal handovers were characterized by an in- and outflow of health care workers (nurses and assistant nurses), while the ward rounds took place in more orderly and calm conditions, and consisted of communication between nurses and physicians.

THE PARTICIPANTS

In this section, the participants from the three empirical studies are presented. First, a description of the participating health care workers is presented, which is then followed by a description of the participating patients. The participants from Study I and Study II are presented jointly, since the same material was used for these studies.

THE HEALTH CARE WORKERS

The health care workers who were involved in the studies for Paper I and Paper II were scattered across six different clinics and hospitals. The head of each clinic selected nurses and physicians based on a diversity in sex, age, and clinical experience in cardiology. Five nurses and

five physicians were selected in total. These health care workers received written information about the study, and all accepted to participate, with written consent. The nurses conducted twelve consultations while the physicians conducted eleven. In the study for Paper I, all of the material that was collected was used, while for Paper II, only the eleven consultations with the physicians were used. The reason for this was that the consultations with the nurses and the physicians differed in their content and structure, and there were no consultations with nurses and non-native Swedish speaking patients (NNS).

The health care workers who were involved in the study for Paper III were all working at the same clinic. Three categories of health care worker were included in the study. They were informed about the study at two different meetings, one with the assistant nurses and nurses, and one with the physicians. After the meetings, the health care workers also received written information about the study. The health care workers were given the opportunity to give consent to their participation in the study. No refusals were received and the ward rounds and verbal handovers could be attended by the researcher without any restrictions. In total, 30 settings were observed and tape-recorded (13 ward rounds and 17 verbal handovers). The participants consisted of nurses and physicians during the ward rounds, and assistant nurses and nurses during the verbal handovers.

THE PATIENTS

Twenty-three patients (thirteen women and ten men) participated in the study for Paper I, and eleven patients participated in the

study for paper II (two NNS and nine NS). The patients were asked by phone by their consulting nurse or physician to take part in the studies, and they were selected based on their sex, age, type of AF, time since diagnosis, type of planned visit, treatment regimen, and their ability to communicate in Swedish. The patients who agreed to participate in the studies then received an information letter about the studies. On their arrival at the clinics, the patients were introduced to one of the researchers, who obtained written consent to tape the consultation. The researcher was not present during the consultations, however. Three accompanying spouses were present during their respective partners' consultations. The mean age among the patients in the study was 70.1 years for the female patients, and 69.9 years for the male patients. In the study on ethnicity, the mean age was 76 years for the NNS and 55 years for the NS.

DATA COLLECTING METHODS

A common feature that was shared by the three empirical studies was that they were based on observations of verbal communication that was taped. For the studies for Paper I and Paper II, the consultations between the nurses and physicians and the patients were taped in the absence of the researcher. One of the nurses or the physician started the tape recorder. The study for Paper III included the presence of a researcher while the ward rounds and verbal handovers took place. With respect to the ward rounds, the patient encounters were not included in the observations since it was the communication *about* the patients that was of interest for the study. The participatory observations (DeWalt & DeWalt, 2002) were used solely as a way to attain access and closeness to the situations where the communication took place. The material consisted of the taped ward rounds and verbal handovers only.

ANALYTICAL FRAMEWORKS AND PROCEDURES

In this section, the analytical frameworks that were used and the procedures that were followed in the empirical papers will be described chronologically. Paper I and Paper II will be presented jointly, while the study for Paper III is presented separately. At this stage, it becomes relevant to also include paper IV, which is also presented separately in the final sub-section.

PAPER I AND PAPER II

The analysis of the material in Paper I (*Gendered communicative construction of patients in consultation settings*) and Paper II (*Communicative construction of native versus non-native Swedish speaking patients in consultation settings*) was inspired by critical discourse analysis (CDA) (Chouliaraki & Fairclough, 1999; Fairclough, 1995, 2001). This consists of a linguistic analysis of how communication patterns take form. Discourse can be seen as a conversation between people (constituting) which is affected by historical and cultural norms of society (constituted). Thus, discourses that have been identified in a specific context can always be linked to a larger context; to other and wider currents of ideas in a society. The power of discourse analysis is that it can highlight "hidden" structures that limit a specific social practice. Because discursive perceptions have consequences in a social practice, CDA was a highly relevant method to use in the two papers. If highlighting and describing the organizational and institutional discourses, the conditions that shape the environment that the patients and the health care workers face may become more visible. If something becomes visible it is also possible to change. CDA can help the researcher draw conclusions about the conditions that hinder

or facilitate the demand for equality, and help the researcher examine the role unconscious assumptions about various social positions play in this respect.

Lund and Sundberg (2004) argue that the object of knowledge of the discipline education can be studied relationally between society and individuals, and between social institutional structures and individual actions. In order to explain its object of knowledge, educational research focuses on the linguistic- and social interaction that people produce and consume in social institutions and practices. The research questions in Paper I and Paper II involve the relationship between health care workers and patients and how they collectively produce and reproduce knowledge about patients' social positions.

Fairclough's (2001) discourse model is divided into three different discourse dimensions ((i) discourse as text, (ii) discourse practice, and (iii) socio-cultural practice). *Text* (constitutes the discourse dimension "discourse as text") comprises of written text, speech, or other semiotic systems that represent and thereby produce social identities and social relations. *Interaction* (constitutes the discourse dimension "discourse practice"), on the other hand, comprises the conditions for the production or consumption of text, which gives this dimension a focus on interpretation and the grounds on which interpretations are made. Finally, *con- text* (constitutes the discourse dimension "socio-cultural practice"), comprises the extrinsic social and cultural conditions from which inter- pretations are derived.

In Paper I and Paper II, I adapted Fairclough's model. I used it as a pragmatic tool for identifying and categorizing communicative patterns in the empirical data which was comprised of consultations

between patients and health care workers (nurses and physicians in Paper I, and physicians in Paper II). Since the common interest in Paper I and Paper II was to highlight the reciprocal communicative construction of the patients, the role of the patients and the role of the health care workers were separated from each other initially. In the *discourse as text* dimension, only the patients and their statements were analyzed. Attention was focused on how they presented themselves and their ailments, in order to capture how they verbally constructed themselves communicatively. In the *discourse practice dimension*, the health care workers were in focus; nurses and physicians in Paper I, and the physicians in Paper II. How the health care workers related to the patients when they responded to their statements and how they asked questions to the patients were analyzed. In the *socio-cultural dimension*, what the consultations culminated in was highlighted by examining the summarizing statements and conclusions that were made by the health care workers and the patients.

First, the transcripts were closely read and patterns of communication that touched on gender (Paper I) and ethnicity (Paper II) were identified through the use of Fairclough's framework as an interpretative frame. The observations were systematized and a coding scheme was developed that was based on variations in the statements that were made by the patients and the health care workers, in reference to aspects of gender and ethnicity respectively. The entire material was then coded accordingly, and statements belonging to each of the three discourse dimensions were also counted in order to establish the frequency of each observed discourse in the total material.

Besides using Fairclough's framework as a pragmatic tool for identifying and categorizing communicative patterns, the analysis in Paper II was

complemented with Linell's dialogic perspective (2009) to further describe and analyze the different discourses. Given that the patient participation, in reference to PCC, and how the health care workers dealt with that from a communicative perspective was of interest, the reciprocal communicative constructions between patients and health care workers were of central importance. Thus, the need to move away from the macro perspective and get closer to the participants and the actual verbal communication became important. This was something to which Linell's perspective could contribute. According to Linell, communication is organized monologically or dialogically. The monological perspective implies a view on communication as a context-dependent act between a sender and a receiver, with primary focus on the language structure. This monological perspective represented an expression of a substandard form of PCC. In the dialogical perspective, on the other hand, communication is regarded as a social interaction, in which social positions such as gender and ethnicity are seen as influencers of the contextual communicative conditions, instead of just being stable categorizations (Linell, 1998). This understanding of communication made the dialogical perspective more compatible with PCC. The dialogical perspective consists of three principles that influence the degree of dialogue. The first principle, *sequentiality*, says that a statement is to be regarded as part of a sequence of statements instead of a just an individual act. This means that in a dialogue, both previous and future statements are linked to the statement made in the present. The second principle, *joint construction*, refers to the mutual construction of meaning in communication, in contrast with a mere transfer of meaning. The third and final principle, *act-activity interdependence*, stipulates that statements are situated in an embedding activity, which the participants produce jointly (Linell, 1998). These three principles were relied upon in the analysis of

the excerpts, and were used to illustrate the various discourses that were present in the different discourse dimensions.

PAPER III

The qualitative content analysis that was performed in Paper III, *Communication about patients in multi-professional teams: A gender perspective*, was inspired by Kvale (1996) and Graneheim and Lundman (2004). As with all forms of qualitative content analysis, the basic issue that a researcher must address concerns the manifest- and the latent content. Manifest content deals primarily with the content on a descriptive level, where the researcher concentrates on the visible and obvious components. Latent content involves the interpretation of "underlying meanings" (Downe-Wamboldt, 1992). Furthermore, selection of the unit for analysis, or simply the basis for the analysis, is also a central step. According to Graneheim and Lundman (2004), the most important thing to keep in mind in for the selection of the unit of analysis is that the unit should be able to form support for the succeeding large set of classifications. The next step, and also the first part of the subsequent classifications, consists of meaning units that through words, sentences, or paragraphs illustrate and express the selected unit in greater detail. These meaning units then become condensed in sense that the selected meaning units are reduced in size but the core content is preserved. The following step is to abstract away from the condensed meaning units by interpreting parts of the text that clarify a specific topic in the material. This abstraction step results in the creation of various labels, called 'codes', to the different condensed meaning units, which together represent different content areas. The coded meaning units are thereafter divided into different categories which mark the manifest content and answer the question "What?". The final step is to further

divide these categories into themes in order to draw attention to the latent content and thus answer the question "How?" (Graneheim and Lundman, 2004; Kvale, 1996).

Initially, the transcripts of the ward rounds and verbal handovers that contain the health care workers' communication about the patients in their absence were read through thoroughly in order to get an estimation of the content. The estimation resulted in a sorting of the text material, and so, in this respect, the analysis process differed somewhat from Graneheim and Lundman's analysis. While they advocate that content areas should be derived from meaning units, the procedure used in Paper III instead derived content areas from the initial couple of readings and estimations, and then based on these readings, subsequently derived meaning units. Two content areas were identified: (i) non- evaluative communication about patients, and (ii) evaluative communication about patients. Thereafter, the meaning units constituted the beginning of a condensing process that began with non-evaluative content and evaluative content being divided into whole sentences and para- graphs (these units constituted the actual meaning units). The next step was to further condense the material. The respective sentences that constituted the meaning units were summarized into one sentence (the condensed meaning units). These were then assigned with specific and substantive concepts (the codes). In the following step, the codes were sorted into sub-themes, which clarified the manifest content in terms of different communicated attitudes towards the absent patients during the ward rounds and verbal handovers. In the final step, the categories were further explored, which generated two themes that served to clarify the latent content.

PAPER IV

The conceptual Paper IV, *The gender subtext of New Public Management based work practices in Swedish health care*, was based on a review and analysis of research and data from the literature. First, searches were conducted in the databases PubMed and Medline using the term "Clinical Microsystem" (CM). CM is a fairly new concept, thus the searches did not generate many findings and none of them contained anything about the model's gender implications. As a result of this, the generic term "New Public Management" (NPM) was used as a search term (since this includes a variety of control- and management models, one of which being CM). This term was searched for together with the term "gender" and without it. A fairly limited amount of relevant literature was found. Notwithstanding this, it was possible to identify a number of interesting and important characteristics within NPM in general, and within CM in particular.

The characteristics that were identified were contrasted against the literature on 'gender in organizations', 'multi-professional collaboration', and 'organizational control'. The latter two terms were found to be the most distinguishing features with respect to the two concepts, 'CM' and 'NPM'. Regarding 'gender in organizations' and 'organizational control', standard works by, for instance, Acker (1992, 2006), Eagly and Karau (2002), together with Standing (1997, 2000) on 'gender', and Barker (1993) and Orlikowski (1991) on 'control' were used for the analysis. With respect to 'multi-professional collaboration', PubMed and Medline were used as databases, which did not generate many findings, but the number of findings was considered sufficient because the concept was one part of a total of three concepts which were contrasted against the

characteristics found in the literature on CM and NPM. Theories on NPM and CM were analyzed from a gender perspective through theories on organizational control. Together, the literature on 'gender in organizations', 'multi-professional collaboration', and 'organizational control' provided a foundation from which theoretical suggestions were made on how the gender implications of CM can be researched.

METHODOLOGICAL DISCUSSION

In this section, I start by discussing the relation between the different methods. The focus will be on how these methods complement each other and on the progression between them in reference to the overall theoretical perspective adopted in this thesis. In the second subsection, I reason about pros and cons of the different methods that were used, from a progressive perspective. In the third and final subsection, I discuss the relevance and trustworthiness of the four papers that are presented in this thesis.

INTERCONNECTIONS AMONG THE STUDIES/PAPERS

The four different studies differed in focus in that they highlighted various aspects of health care communication (verbal interpersonal communication, as well as organizational and institutional communication) in relation to social positions. Paper I and Paper II presented a discussion of how specific social positions, gender and ethnicity respectively, are enacted and expressed in communication with patients. Paper III expanded on this discussion partly by paying attention to patients perceived as not acting or behaving according to socially accepted gender norms, and partly by moving the focus to the staffs' communication *about* patients. Paper IV, with its focus on the NPM inspired CM, demarcated the context in which the three previous studies were carried

out. Below, the analytical frameworks that were used in Paper I and Paper II (CDA) will be merged with the analytical framework that was used in Paper III (the qualitative content analysis).

There are both similarities and differences between CDA and qualitative content analysis. Hardy, Harley, and Phillips (2004) stress that discourse analysis and traditional content analysis have different ontological and epistemological bases which make them complementary to each other. The ontological differences indicate, according to Herrera and Braumoeller (2004), that analysts who use content analysis accept the premise of a fixed and objective reality, whereas the intersubjective construction and interpretation of reality is ascribed to analysts who are engaged in discourse analysis, which also implies a positivist epistemological standpoint for content analysis, and an interpretative epistemology for discourse analysis (Neuendorf, 2004). In the former, the separation of ontology and epistemology becomes a natural consequence as the objects or subjects are fractionated from the mediated labels attached to them (Fierke, 2004). For instance, the term *patient* and the various as- sumptions that are connected to it are not constitutive of what it means to be a patient. According to Fierke, the opposite is true for discourse analysis; the object or subjects are intimately linked to and interdepend- ent of the mediated labels that are attached to them. In other words, the term *patient* and the various assumptions connected to it constitute and are constituted by what it means to be a patient, which makes the sepa- ration of ontology and epistemology an impossibility (Fierke, 2004).

These ontological and epistemological differences, however, vary greatly in magnitude within each of the frameworks; CDA and qualitative con-

tent analysis have much in common. According to Fairclough (1995, 2001), discourses constitute as well as are constituted, which implies an interdependence on other social practices and social processes. Lowe (2004) argues that, by clarifying and making the assumptions that guide the analytical work with content analysis explicit, versatility increases and contributes to bridging the gaps between content analysis and discourse analysis. In the qualitative content analysis that was done for this thesis, the grounds on which the meaning units were derived (content areas) were already made explicit in the initial readings. Conceptions that are made early on in the analysis form the continued analysis and can hardly be ignored.

Consequently, the relevant discourse dimensions also emerged from the initial couple of readings of the material. Moreover, the themes that reveal the "underlying content" in the qualitative content analysis are, in many ways, consistent with the discourses that were identified in the discourse analysis. In Paper III, I analyzed the latent content, by highlighting interpretive aspects of the discourse, and not only descriptive aspects of the discourse. This distances my analysis from traditional content analysis as proposed by Herrera and Braumoeller (2004) and Neuendorf (2004). Although, Foucault (1993) argues that it makes little or no sense to search for any underlying (or manifest) truth on "the nature of things" it does lie in the interpretive and subjective traditions' nature, of which both of the analytical frameworks are a part based on how they are used, not to specifically advocate one particular interpretation and disqualify all others (White, 2004). According to Foucault (1993), our understanding of reality is limited to our interpretations and explanations of the prevailing discourses of which we are a part.

Both of the analytical frameworks that were used in this thesis have

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clear links to the overall approach of this thesis, namely social constructionism. Albeit expressed differently than with the hermeneutical phraseology used by Neuendorf (2004), Nikander (2007) concurs that discursive approaches, regardless of alignment, share a social constructionist epistemology in that language is considered as more than solely a reflection of the world, and that discourses are central to the construction of the understandings, ideas, and social processes that constitute our social world. Thus, language represents the social world. This is supported by White (2004) who sees discourse as a result of meaningmaking, which is expressed through speech, writing, actions, and products that are active in our social world. To return to qualitative content analysis, in accordance to Graneheim and Lundman (2004), there are always multiple meanings *about* reality and perceptions *of* reality, and therefore, as Elo and Kyngas (2008) claim, the aim of the analysis becomes to identify condensed and broad descriptions in terms of concepts or categories that express one or several understandings of a particular phenomenon.

The reasoning above should clarify my claim that the different analytical frameworks, despite their seeming differences, nevertheless can contribute to understandings of how social positions are enacted and expressed in health care communication. For this purpose, I examined the discourses and content areas that were identified in the different contexts (the consultations, ward rounds, and verbal handovers), how they constitute or influence the communication, and how they were constituted or influenced by the communication.

MOTIVES FOR VARYING THE ANALYTICAL FRAMEWORKS

With my interest directed toward communication and its constructive aspects in relation to social positions, discourse analysis appeared as a fruitful choice in terms of analytical framework, early on in my investigations. Having decided to use discourse analysis for the first paper, *Gendered communicative construction of patients in consultation settings*, the next question was to decide on which alignment I found most suitable. Critical discourse analysis (CDA) offered a desirable pragmatic structure (the discourse dimensions), and, at the same time, it included a definition of discourse which was not limited to the individual communicative context; instead, the definition of discourse drew attention to external factors that influenced the actual communication, as well as the communicative context. However, after the completion of Paper I, I found that the pragmatic structure had some, for my purposes, restrictions. It certainly contributed with a useful tool for structuring the various discourses, but due to my interest in examining both the patients' and the health care workers' communicative contributions, this tool became *too* structured (hence the different division in terms of the discourse dimensions in Paper I and Paper II). Furthermore, opportunities to get close to the data (the text and the actual communication) were also thereby somewhat limited. This was the reason why I supplemented the CDA with the dialogic perspective that is adopted in Paper II, *Communicative construction of native versus non-native Swedish speaking patients in consultation settings*. This enabled me to use CDA as a macro-framework and the dialogic perspective as a micro-framework.

The desire to maintain closeness to the data, without losing sight of potential external factors that may have influenced the communication and

the communicative context, lead me to perform a qualitative content analysis for Paper III, *Communication about patients in multi-professional teams: A gender perspective*. There is also the fact that the communicative context in Paper III differed from the contexts in Paper I and Paper II. Whereas the communication was performed by two parties and individuals in Paper I and Paper II, (patients in consultations with either nurses or physicians in Paper I, and with physicians in Paper II), the communication in Paper III consisted of group conversations with several individuals involved. This led me to abandon the dialogic perspective. Although it is by no means impossible to analyze dialogic (and monologic) processes in communication between more than two people, I perceived the dialogic perspective as not sufficient enough to constitute the entire analytical framework by itself, as I simultaneously abandoned CDA. I could, of course, have adopted a more flexible alignment of discourse analysis (for instance, as outlined by Foucault). However, I sought a framework that could fulfil my requirements regarding explicit focus on both the text and the actual communication, as well as on potential external factors that may have influenced the communication and the communicative context. At the same time, I had not fully given up on structured frameworks either. Thus, the choice fell on qualitative content analysis, which was considered to be the most suitable framework considering purposes, although adjustments to the framework were made in order to make it even more suitable.

RELEVANCE AND TRUSTWORTHINESS

Even if health care workers at the participating clinics communicate stereotypes and prejudices about the patients that are linked to the patients' social positions, and that these patients themselves contribute to the construction of limited- and limiting social identities, how significant

is this in a broader sense? In Paper II, *Communicative construction of native versus non-native Swedish speaking patients in consultation settings*, I relate to this issue through Shenton's (2004) understanding of Guba's (1981) four concepts: 'credibility', 'transferability', 'dependability', and 'confirmability'. These concepts form the basis of the present discussion as well, complemented with further references.

'Credibility' is the most significant of the four concepts and concerns the capturing of the phenomenon that is the subject of the research. In order to increase credibility, the knowledge about the phenomenon and how this knowledge has been acquired is important. This covers everything from (i) appropriate data collection methods, (ii) familiarity with the context within which the data collection is to take place, (iii) previous research on the phenomenon, and (iv) clarification of the researcher's scientific motives. When credibility is ensured, it facilitates the provision of the three other concepts. 'Transferability' exists on the grounds that the context of the study and the phenomenon is so detailed that it is possible to make comparisons to other studies. 'Dependability' is based on the description of the method(s) that were used. Finally, 'confirmability' is assured by clarification of the researcher's predispositions and the use of triangulation, if possible (Denzin & Lincoln, 2011; Guba, 1981; Graneheim & Lundman, 2004; Quinn Patton, 2002; Shenton, 2004). Since a single article does not allow enough space for a full elabouration of these four concepts, I now complement my earlier articles with a discussion of these concepts as they relate to the thesis as a whole.

Discriminatory expressions in interpersonal and organizational communication within health care practices, is a complex phenomenon spanning over several fields and disciplines. Credibility and transparency were increased by a step by step procedure. I first divided the phe-

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nomenon into separate parts, including discrimination, health care, social positions, communication, and the organization respectively, and described them separately. This increased our understanding of each of the parts and made them more transparent, before they were subsequently merged together again. Through this process, the decisions regarding data-collecting methods were made based on extensive theoretical knowledge about the phenomenon that was the subject of research. This insight was subsequently supplemented by an extended understanding of the context of health care, and, eventually, the specific clinics that participated in the studies. This contextual understanding was facilitated by that fact that I was able to interact with both researchers and practitioners resident in health care and nursing.

The comprehensive description of the phenomenon and its separate parts, together with the extensive explanation of the organizational context as well as the local contexts, provides reasonable conditions for transferability of the study to other contexts. Of course, my theoretical point of departure, my overall aim of this thesis, and the individual purposes of the papers affect these conditions, as well as the dependability and confirmability of the studies. However, previous research on this subject gives me fairly strong support for claiming that one will find discriminatory communication with reference to gender and ethnicity in these contexts. Moreover, the theoretical chapter and the earlier sections of this present chapter clarify the point of departure that was used for the interpretation of the empirical data and the actual implementation of the analyses.

ETHICAL CONSIDERATIONS

The ethical considerations made in the three empirical studies are based on the principles formulated in the Declaration of Helsinki (The World Medical Association, 1964), its revised version (The World Medical Association, 2008), the Swedish Ethical Review Act (Svensk författningssamling, 2003), and the Swedish Research Council's report on "Good research practice" (2011). Although the present research and the three empirical studies should not be considered as medical research, the four documents referred to above argue that all research that can affect the research subject mentally or physically shall conduct an ethics application.

The studies included in Paper I and Paper II was given ethical approval by the Ethical Committee of the Central Ethical Review Board in Linköping and permission to do the studies was also obtained from the selected clinics. Since the approval was originally granted for a different study (Siouta, Broström et al., 2012), I had to submit a separate application where I requested access to the material that had been collected by that time. This application was accepted. The ethics application for Paper III however, encountered resistance. The original intention was to conduct research using an interactive research approach (Aagaard Nielsen & Svensson, 2006), but the Regional Ethical Review Board in Linköping rejected the application because of the proposed interactive approach. They found that the combination of communication about patients in their absence and the interactive approach would be inappropriate because some of the staff from the participating clinic would be given the opportunity to analyze the data that would be collected. This process would, according to the Regional Ethical Review Board,

pose a risk since the analytical staff may have becoming aware of any stereotypes and prejudices towards certain patients or patient groups that may have been verbally communicated by their colleagues. In other words, there was an argument that potential disadvantages would over-shadow the possible benefits of the study. Consequently, the interactive research approach was removed from the proposed study and an appeal was submitted to the National Ethics Committee in Stockholm. The revised study was then approved by this committee.

FINDINGS OF THE FOUR STUDIES

This chapter presents the findings of the Papers I, II, III, and IV. The findings are related to the overall aim of this thesis, which is to contribute to our understanding of how discrimination is expressed in interpersonal and organizational communication within health care, and to high- light educational implications for health care practice. Below, the table provides a comprehensive view over the individual papers' research contribution.

Summary of papers	Paper I	Paper II	Paper III	Paper IV
Main results	Communicative construction of male patients as 'competent' and female patients as 'fragile'.	PCC did not work according to theory. Participating patients were met by argumentation. Amenable patients were met by accommodating responses.	Patients perceived as not acting according to socially accepted gender norms were judged. Patients perceived as acting according to socially accepted gender norms were not judged.	NPM and CM may cause decreased autonomy and increased administrative control. The construction of the innovative and flexible worker reproduces the gender order.
Conclusions	Both patients and health care workers reproduce the gender order. Unequal care may result. Open questions create a setting that is less prone to be limited by gender stereotypes.	A questioning of whether PCC is feasible, or a theoretical and administrative idea difficult to implement.	Negative and disparaging statements when patients are perceived as not acting according to socially accepted gender norms.	New management models must be evaluated for their gender implications. Formal merit systems support gender equality in the work place.

Contribution	How gender stereotypes are reciprocally expressed and how discrimination is enacted in communication between patients and health care workers.	How ethnic stereotypes are reciprocally expressed and discrimination enacted in communication between patients and health care workers. How PCC creates tension in consultations.	How patients perceived as acting according to socially accepted gender norms versus patients perceived as not acting according to socially accepted gender norms are talked about. How patients perceived as not acting according to socially accepted gender norms are disparaged.	How discrimination can be unconsciously built into an organization through a NPM-inspired management model.
Educational implications	Advocating education for health care workers on the social construction of gender and communication.	Advocating education for health care workers on the social construction of ethnicity and PCC from a professional perspective.	Advocating education for health care workers concerning communication	Making conditions for multi-professional collaboration transparent.

Table 3. Overview of the main results, conclusions, and contributions of the four papers that are included in this thesis.

The findings of each paper are linked to the individual paper's purpose(s) as well as to the overall aim of the thesis, as described below:

Paper I – Gendered communicative construction of patients in consultation settings

Critical discourse analysis (CDA), with reference primarily to Fairclough (2001), provided a tool for categorizing and analyzing communicative

patterns in consultations between patients, and nurses and physicians. These patterns revealed that male and female patients, in a reciprocal manner, were communicatively constructed in different ways. These patterns also showed what these differences consisted of. This paper contributed to the research by clarifying how discrimination can be ex- pressed in interpersonal communication from a gender perspective.

Paper II – Communicative construction of native versus non-native Swedish speaking patients in consultation settings

CDA was complemented with dialogue analysis (Linell, 2009) in order to enable a closer analysis of the reciprocal verbal communication be-tween physicians and patients. CDA was used in a similar manner as in Paper I. The communicative patterns that were identified were further analyzed from a dialogical perspective in order to elucidate that Native Swedish speaking patients (NS) and Non-native Swedish speaking patients (NNS) were communicatively constructed in different ways and how these differences were expressed. This paper contributed to the research by explaining how ethnic discrimination can be expressed in interpersonal communication.

Paper III – Communication about patients in multi-professional teams: A gender perspective

Qualitative content analysis (Graneheim & Lundman, 2004) enabled an examination of the content of communication that was produced by health care workers as they discussed their patients during ward rounds and verbal handovers. By performing this examination, it was possible for the researcher to uncover differences between how the health care workers communicated about patients perceived as acting or

behaving according to socially accepted gender norms and patients perceived as not acting or behaving according to socially accepted gender norms. This paper complemented the previous two papers on communication *with* patients by adding and analysis of communication *about* patients, and thereby expanded our understanding of how discrimination can be expressed in interpersonal communication.

Paper IV – The gender subtext of New Public Management-based work practices in Swedish health care

The gender analysis of the NPM model, CM, which included a multi-professional perspective, helped to create an understanding of the organizational context in which communication with and about patients was produced. By establishing the fact that reductions of personal and professional control differ in extent between female and male health care workers, this paper contributes to our understanding of how discrimination can be expressed in organizational communication.

GENDERED COMMUNICATIVE CONSTRUC-TION OF PATIENTS IN CONSULTATION SETTINGS (PAPER I)

Paper I addressed the reciprocal communicative construction of male and female patients in consultations with nurses and physicians. The CDA focused on the patients' presentation of themselves and their ailments, the health care workers' responses and questions that were directed towards the patients, and the summations of the consultations.

Throughout the analysis, the way in which the male and female patients

presented themselves and their ailments was consistent with the manner in which the health care workers responded to and asked questions about the patients. In the discourse that was mostly accessible to the male patients – *performing patient discourse* – the male patients tended to describe themselves and their ailments by using statements about their physical activity; for example, by describing their ability to perform exercise even though they suffered from atrial fibrillation (AF). This may have indicated that the consequences of their ailment were fairly undramatic, since the ailment was perceived to cause only minor limitations with respect to their performance of physical activity. In the corresponding discourse which included the female patients – *emotional patient discourse* – the female patients would often use emotions in order to describe themselves and their ailments; for example, in terms of fear and anxiety regarding the symptoms. This may have indicated that the consequences of the ailment were rather dramatic, contributing to severe limitations in daily life due to various fears and anxieties. This constituted and was constituted by the health care workers' use of different discourses towards the male and female patients respectively. In the discourse primarily drawn upon in consultations with the male patients – *confirmation discourse* – the health care workers' responses and questions were mainly constituted by disarming statements and positive leading questions, which appeared logical given the way in which the male patients presented themselves and their ailment. In the discourse primarily drawn upon in consultations with the female patients – *assurance discourse* – the health care workers' responses and questions were mainly constituted of dramatic statements and negative leading questions, which were fully compatible with the statements that were provided by the female patients. The differences that were demonstrated thus far were further highlighted when the consultations were summed up. In the consultations with the male patients, the *carefree discourse* was primarily used,

which meant that neither the patients themselves nor the health care workers expressed any particular concern about the status of the male patients' health. In the consultations with the female patients, the *concerned discourse* was primarily used, which meant that the patients, as well as the health care workers, expressed extensive concern regarding the status of the female patients' health. Thus, the male patients were communicatively constructed as competent and without need of further care or specialized care, whereas the female patients were communicatively constructed as fragile and in need of further care or specialized care.

Although there were marked differences in the consultations with the male and female patients regarding gendered communicative construction, there were exceptions which formed a sort of 'counter-discourse'. This counter-discourse arose in some of the consultations when the questions that were addressed to the patients were open questions instead of leading questions. The open questions resulted in a remarkably high number of statements that contained negative references and dramatic summarizing conclusions with respect to several of the male patients.

THE COMMUNICATIVE CONSTRUCTION OF NATIVE SWEDISH SPEAKING PATIENTS VERSUS NON-NATIVE SWEDISH SPEAKNING PATIENTS IN CONSULTATION SETTINGS (PAPER II)

Paper II explored the concept of patient-centered care (PCC) in relation to how it manifests itself towards native Swedish speaking patients (NS) and non-native Swedish speaking patients (NNS) in consultations with physicians. The CDA focused on verbally communicated assumptions about NS and NNS, and how these assumptions influenced how the PCC was made manifest in the different consultations.

The findings of this study showed that, in cases where the patients adopted a non-docile and participating role, the consultations were primarily characterized by monologues between the patients and the physicians. This was reflected throughout the discourses that were identified.

In the discourse mostly accessible to the NNS – *participating patient discourse* – the patients expressed dissatisfaction with (i) their previous experiences of substandard care or with the ailment itself, (ii) demands and proposals for specific treatments, and (iii) with their expectations of what the consultations would lead to. This was met by the consulting physicians' predominant use of the *argumentative physician discourse* towards the NNS, which contained contradictions to, and questions of, the patients' point of view. Consequently, when the consultations with the NNS were summed up, the *preservative discourse* was mainly drawn upon, which was comprised of the assumption that the NNS did not need any further care, or specialized care.

In contrast to the consultations with the NNS, the findings of the study pointed out that in cases where patients adopted a docile role, the consultations were primarily characterized by dialogue and accommodations between the patient and the physician. In the discourse that was mostly accessible to the NS – *amenable patient discourse* – patients expressed gratitude regarding the state of things and their experience of the health care that had been provided to them, and they agreed with what the physician said or proposed to a large extent. This was met by the physicians' use of the *acknowledging physician discourse* towards the NS, which contained confirmation of the patients' statements. When these consultations were summarized, the *monitoring discourse* was mainly drawn upon, which was comprised of the assumption that the NS needed further

care, or even specialized care.

COMMUNICATION ABOUT PATIENTS IN MULTI- PROFESSIONAL TEAMS: A GENDER PERSPECTIVE (PAPER III)

Paper III addressed how health care workers communicated *about* patients in their (the patients') absence. The qualitative content analysis that was used in this study focused on the shift from professional communication to informal communication.

When the patients were perceived as acting or behaving according to socially accepted gender norms, the health care workers used professional communication. This meant that the various statements made by the health care workers primarily contained medical content, and that the non-medical content that still existed and constituted the perceived gender-stereotypical acting was not judged or evaluated by the health care workers. This was clearly expressed when stereotypical expectations regarding women's and men's caring abilities were expressed. For instance, in the fact that a female patient worried about her perfectly healthy husband at home was not questioned by the health care workers. On the other hand, the health care workers were happy that a male patient had a fit and healthy wife at home who could take care of him. In both cases the health care workers expressed their understanding for a man's need for a caring wife, irrespective of which partner was ill. The fact that that some female patients also showed tearfulness was mentioned, and was declared as reasonable, given their medical condition.

When the patients were perceived as not acting or behaving according to socially accepted gender norms, the health care workers communicated in an informal way. This type of communication mainly contained non-medical content of a judgmental nature. This was exemplified by

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disparaging statements about a (perceived) tearful male patient, or statements which imitated a (perceived) whining, loud, and ungrateful female patient.

THE GENDER SUBTEXT OF NEW PUBLIC MANAGEMENT-BASED WORK PRACTICES IN SWEDISH HEALTH CARE (PAPER IV)

Paper IV addressed the gender implications of the Clinical Microsystem (CM) health care organizational model. The analysis that is presented in this paper focused on the literature on gender in organizations, NPM, multi-professional collaboration, and organizational control.

In CM, focus lies not only on the end product of quality care, but also on the work processes associated with the provision of such care. This focus on the work processes demands that the work that is performed by health care workers be measured and monitored. This, in turn, results in a reduction of the health care workers' autonomy, in terms of the professional- and personal control previously enjoyed by these workers. Instead, the systemic control that is held by health care administrators increases, since they are responsible for measuring and monitoring the work processes. The health care workers are, however, given some influence over this process of surveillance; they themselves are accountable for producing these various types of measures. The practical implications of decreased professional- and personal control create difficulties for health care workers in how they influence their own work situation. It also becomes harder for these workers to gain insight into whom or what actually manages their work processes.

Instead of being influenced by traditional hierarchical and meritocratic organizational structures, CM is influenced by more informal structures

and control incentives, as proposed by the discourses of systemic control and NPM. By stressing the development of a co-worker culture that is comprised of multi-professional collaboration and consensus, health care workers are governed to act in prescribed ways, such as being collaborative and flexible, and display these appropriate attitudes in order to exercise influence in the workplace. Thus, the systemic control influences the workplace culture, including the employees' shared norms, attitudes, perceptions, and values. This consensus-oriented culture may create a culture of blindness in which differences and conflicts between different groups of professionals are suppressed or made invisible. In addition to this, the strongly gendered professional cultures that health care organizations consist of create invisible walls and territorial thinking, which influence staff perspectives on cooperation. When behavioural and social competencies and attitudes are included in detailed job descriptions, this tends to benefit the group that is currently in power. When formal control incentives are replaced by informal incentives, and when organizations are flattened and made less bureaucratic, this tends to disfavour women. Thus, inter-professional cooperation becomes *cooperation on unequal terms*, and may help strengthen rather than challenge entrenched hierarchical gender patterns.

DISCUSSION

In this chapter, the main findings from the four papers will be revisited and discussed in reference to the overall aim in order to contribute to our understanding of how discrimination is expressed in interpersonal and organizational communication within health care, and to highlight educational implications for health care practice. In total, this chapter consists of two sections. In the first section, the communicative construction will be discussed from the patient's perspective as well as from the health care worker's perspective. This discussion is based on the results from papers I, II, and III. This discussion responds to the interpersonal communication aspects that are part of the overall aim of this thesis. In the second section, I place interpersonal communication in an organizational perspective, based on the results found in Paper IV.

Papers I, II, and III have paid attention to the communicative construction directed towards, and executed by, both patients and health care workers. In addition, they have also explored how these communicative constructions vary depending on which social position is prominent in the respective communicative context. Paper IV contributed with an extended understanding on how the New Public Management-inspired (NPM) management model, Clinical Microsystem (CM), influences the health care organization and makes it more difficult to enforce the demand for equality, at least from a gender perspective. I will now respond to the overall aim, with the help of contributions from each paper, starting at the micro level, which is constituted of patients, individual health

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care workers, and multi-professional health care teams. I will then move to the macro level, which is comprised of the health care organization.

COMMUNICATIVE CONSTRUCTION AND DISCRIMINATION LINKED TO PATIENTS' SOCIAL POSITIONS

This section consists of two sub-sections, which is divided between the patients' and the health care workers' contribution to the communicative construction respectively.

THE PATIENTS' SELF-CONSTRUCTION

Papers I, II, and III demonstrated how patients were verbally communicatively constructed during consultations, ward rounds, and verbal handovers based on their alignment to certain social positions (gender and ethnicity). From the patients' perspective, the limitations to their self-construction and their construction of their social identities were illustrated through their own contribution in the communication. The patients seemed to express stereotypical assumptions about themselves (Ridgeway & Correll, 2004), in terms of them having internalized the notion of segregation (Acker, 1992; Essed, 2005; Hyde, 2005). Through the use of stereotypes, the patients learned, at least temporarily, to internalize a self-image that was analogous to socially-accepted norms. This was most clearly expressed in Paper I, where both the female and male patients drew on gender-stereotyped discourses. In Paper II, the separation between the Swedes and "the others" took the form of different approaches towards the patient role. Participating and active non-native Swedish speaking patients (NNS) were contrasted to amenable and passive native Swedish speaking patients (NS).

Thus, the procedures that were employed by different patients in constructing themselves and their social identities differed between the social positions. The female patients, who primarily drew on an emotional discourse, and the male patients, who mostly drew on an performance-oriented discourse, acted and communicated with the health care workers in accordance with gender stereotypes (Ahl, 2006, 2007; Brown & Diekman, 2010; Eagly & Karau, 2002; Kite et al., 2008; Koenig et al., 2011; Wood & Eagly, 2009). Consequently, the gendered communicative construction of and by the patients was based on a sort of adaptation to stereotypes, or an unwillingness to assume the role of a counter-stereotypical actor (Phelan & Rudman, 2010). The same can be said regarding the NS patients who, with their amenable and passive approach in the consultations, avoided challenging the authority of the health care worker (the physicians in this case). Even though the new patient ideal, as endorsed by NPM and CM in general, and by PCC in particular, emphasizes participation and influence (Cahill, 1998; Committee on Quality of Health care in America, 2001; Sidani, 2008; Socialstyrelsen, 2006), the medical-driven agenda (Siouta, Broström et al., 2012; Siouta, Hedberg et al., 2012) and the uneven power balance between patients and health care workers (Vinthagen, 2007), creates different conditions for participation for the patients and the health care workers; the health care worker usually has the preferential right of interpretation. Moreover, studies have shown both the presence of a negative attitude toward patient-involvement amongst physicians (Falkum & Förde, 2001), and that, even when the attitudes are positive, patient-involvement has not been significantly realised (Audet, Davis, & Schoenbaum, 2006). These combined conditions may well explain, at least partly, why the NS patients drew on the amenable patient discourse. It can also provide an

understanding of the communicative construction of the NNS, who unlike the previous patient groups, was based on a clearly counter-stereotypical approach (Phelan & Rudman, 2010). This idea of patient participation and involvement which is sanctioned from a legislative and organizational perspective, and which the NNS executed, did not appear to be fully internalized by the health care workers. This claim is based on how they dealt with and responded to patients who communicated and acted in alignment with PCC, which may explain their argumentative attitude during these consultations.

THE HEALTH CARE WORKERS' CONSTRUCTION

Turning to the health care workers and their role in the verbal communicative construction of the patients, their communicative contribution is in many ways consistent with the patients' communicative contributions. The gender stereotypes that were used and mediated by the patients in Paper I may be seen as having contributed to consensus in the consultations, since the consultations contained statements from both parties that mutually confirmed and reinforced gender stereotypes. Likewise, the amenable approach of the NS patients in Paper II guaranteed an unquestioned authority among the physicians, which retained the superiority and subordination relationship between the professional health care worker and the patient (Vinthagen, 2007). Regarding the consultations with the NNS, who communicated and acted in alignment with PCC, a counter-stereotypical approach was represented, where a resistance against the preordained superiority and subordination relationship appeared. This resulted in dissent which was revealed by the many recurrent argumentative statements made by the physicians. This state of affairs also applied in Paper III, where stereotypical acting (*per-*

ceived stereotypical acting in this case since it concerned communication about patients in their absence) contributed to the production of communication about the patient which did not contain any disparaging statements. In contrast, counter-stereotypical acting resulted in a shift from professional communication to informal communication, where disparaging statements about the patients occurred. Counter-stereotypical acting, whether it was verbally expressed and made explicit by the actors themselves, or was merely a perception among the health care workers, accentuated the social positions of gender and ethnicity. This happened when patients did not act according to stereotypes. Alternative or multiple expressions of gender and ethnicity should theoretically have brought accommodation processes to the fore among the health care workers. That this counter-stereotypical behaviour was met by resistance and argumentative approaches from the health care workers suggests that assimilation was used by the health care workers in order to maintain equilibrium (Illeris, 2001), or to maintain segregation between the sexes (Acker, 1992; Hyde, 2005), and between Swedish and foreign-born patients (Essed, 2005).

What then, does the above suggest? Drawing attention to the types of discrimination, there seems to be examples of, at least to some extent, direct discrimination, in the sense that native Swedish speaking female patients, are singled out as being of greatest need in terms of further care, or specialized care, when compared with Swedish speaking men and non-native Swedish speaking patients (NNS). Although clinical aspects were not included in the studies (the further care or specialized care that was advocated through the summarized conclusions of the consultations with the female patients was not followed up on), these

results are nevertheless interesting. On the one hand, these results do not correspond with previous research on how women and men are treated in health care settings, for example, where it is claimed that men are given better care (Smirthwaite, 2007), or that they receive more thorough treatments and undergo more tests (Socialstyrelsen, 2004). On the other hand, they simultaneously confirm research projects that have noted the presence of stereotypes about women as the weaker sex (Johannisson, 1994; Socialstyrelsen, 2004)

Certainly, every patient is unique (hence patient-centered care). The same medical condition may very well take on different forms, and may be experienced in different ways by different patients. But when we contrast different patient groups, the different treatments these patient groups were provided became clear. The preponderance of accommodating interpersonal treatments and consultation summaries that were given to women over men, and a similar pattern of favourable treatment that was provided to NS patients over NSS patients, as well as the presence of disparaging statements about perceived counter-stereotypical actors, signals a form of systematic difference-making on the grounds of the patients' social positions. Stereotyped assumptions and expectations that were mediated by leading statements and questions, as well as by disparaging judgments, caused patient-centeredness to be exaggerated into a sort of hypersensitivity towards the patients' alignment to social positions.

After having discussed the verbal communicative construction of the patients from the perspective of the patient as well as the health care worker, I will now turn to the health care organization and examine the

conditions that it sets for the health care practices and the communication.

AN EQUALITY-ENABLING OR EQUALITY-IMPEDING ORGANIZATION?

Health care workers are expected to perform their duties, including satisfying the demand for equality in the provision of care when they meet patients (Socialstyrelsen, 2006). However, this is supposed to take place in an organization in which other demands compete for attention and also influence the prevailing organizational discourse. As Paper IV indicated (with its focus on CM), the organizational conditions in the Swedish health care system have changed, where we see that the NPM discourse with its performance paradigm has grown to be increasingly influential. The values and ideals that are now advocated for influence the institutionalized discourse and the organizational culture. Health care workers, to varying degrees, now have to adapt to the new conditions in order to conform to the equally important demand for consensus within health care (Wall, 2009). Together, this constitutes an organizational culture that is characterized by change-orientation, which requires new or modified forms of competencies among the health care workers; competencies that the new form of health care worker should embrace.

But what are the conditions for learning within a health care organization, if by *learning* we also mean developing the worker's abilities to act in an unprejudiced, non-discriminatory, and democratic manner? We are dealing with an organization within which the institutionalized discourse is inspired by ideals that advocate (i) standardization (Kaplan & Norton, 1992; Nelson et al., 2007; Nelson, Mohr, Batalden, & Plume, 1996),

(ii) consensus (Wall, 2009), and (iii) error minimization (Lagrosen & Lagrosen, 2009). In addition to these ideals, we have seen concomitant reduction of the health care workers' professional and personal control in the workplace (Abernethy & Stoelwinder, 1995; Abrahamsson & Johansson, 2008; Hedegaard & Ahl, 2013). All these factors run counter to what Ellström (2005) claims is characteristic of an enabling learning environment. Moreover, Kray and Shirako (2011) stress that in evaluation-intensive environments, such as health care (or any other environment inspired by NPM for that matter), there is a risk that expectations and evaluations become intertwined, which may lead to people being exposed to stereotypes, become more prone to unwittingly confirm negative expectations, or, to use Rosenthal and Jacobson's (2003) term, it creates 'self-fulfilling prophecies'. Thus, it appears to be difficult to embrace the ideals that are inspired by NPM and, at the same time, enable conditions for autonomy and critical reflection within the organization, which are significant elements for achieving learning and development, instead of mere adjustment (Ellström, 2005). In summary, it becomes increasingly difficult in an organizational culture like this to challenge prevailing social orders (Hedegaard & Ahl, 2013). In an organization of this kind, the question is what kind of knowledge and meaning is being generated?

The predominant ideals within health care contribute to intra-organizational discrimination. The emphasis on multi-professional collaboration and continuous improvement work, as proposed by NPM (Leonard et al., 2004; Williams, Dickinson, & Robinson, 2009; Williams et al., 2007), may very well lead to a situation where the behaviour and personal characteristics of health care workers becomes increasingly

significant (Frush, Sherwood, Wright, & Segall, 2012; O'Leary et al., 2011). Attitudes or dispositions toward collaboration and change becomes key competences to hold, and are, together with formal competencies, included in job descriptions. Thus, through an increase of the importance of informal and opaque competences, nepotism and cronyism are given more scope at the expense of meritocracy (Hedegaard & Ahl, 2013). This state of affairs is difficult to reconcile with the ideals of an equal workplace.

CONCLUSION AND IMPLICATIONS

The overall aim of this thesis was to contribute to the understanding of how discrimination is expressed in interpersonal and organizational communication within health care, and highlight educational implications for health care practice. This study has shown that discrimination in this context consisted of the communication that is comprised of (reciprocally) reproduced gender and ethnic stereotypes, as well as contradictions about and disparaging remarks on expressed and perceived counter-stereotypes with in reference to gender. Gender discrimination can be understood as gender stereotypes that were made explicit and verbally expressed through communication in the health care settings that were examined. This discrimination was transmitted back and forth between the communicating parties. With respect to ethnic discrimination, it did not appear that ethnic stereotypes were verbally expressed. Instead, they represented an implicit form of discrimination that informed different discourses, and thereby facilitated the communicating parties to adopt different communicative roles. Furthermore, this study also provided an expanded understanding of how the organizational and institutional discourse influences the conditions for communication, and the demand for equality can be met within health care practice. Through the implementation and execution of the NPM-inspired model, CM, the advocacy of standardization, measurements, streamlining, and rationalization communicated an order of priorities that, in practice, complicated the conditions for the health care organization to create an equitable workplace, and made it difficult for health care workers to fulfil the demand for equality for their patients.

Although the patients' communicative contributions have been examined in this thesis, the responsibility for creating equal communication within health care, has to, be attributed the health care workers and health care teams, as well as the health care organization, first and foremost (Vinthagen, 2007), however much the patient's responsibility may have increased through the implementation of PCC. Health care workers continuously construct the organization through their acts of communication and thereby constitute the prevailing discourse (Johansson, 2007). However, at the same time, the local context is conditioned by the prevailing organizational discourses, which, in this case, seemed to limit the conditions by which the demand for equality could be met.

A common thread throughout this thesis has been the struggle between efficiency versus equality in health care; a struggle that researchers, as well as various health administrators have noticed and examined for many years (Bevan et al., 2010). Models, tools, and concepts that are designed to address efficiency problems have been contrasted against its implications for equality (e.g. PCC, holistic care, and CM). Such a division can, however, be unfortunate since it is based on an assumption that the two are equivalent, when, in fact, it may be advantageous to regard efficiency as a means and equity as an end to that means, instead (Reidpath, Olafsdottir, Pokhrel, & Allotey, 2012). However, from the perspective of the health care worker, this struggle inevitably affects their work. Health care workers are, like many other professionals, exposed to a plethora of directives, models, tools, and concepts (Abrahamsson & Johansson, 2008; Henriks & Berger, 2007; Leonard et al., 2004; Nelson et al., 2007), but they are often only offered limited opportunities to apply these directives and so on that the complex health care

organization requires (Johnson, 2010; Nelson, Gardent, Shulman, & Splaine, 2010).

This implies that we need a new form of health care worker or professional (Hedegaard & Ahl, 2013). A health care worker who, on one hand, has seen a reduction in both their professional and personal control (Abernethy & Stoelwinder, 1995; Abrahamsson & Johansson, 2008), but on the other hand, in accordance with the ideals advocated by the influential NPM discourse (Agevall, 2005; Björk, Forsberg Kankkunen, & Bejerot, 2011; Dahlgren, 2010; Martinussen & Magnussen, 2009), is expected to, engage in all types of development work, parallel to their regular duties; for example, by implementing sundry "innovative" models, tools, and concepts (Batalden & Davidoff, 2007; Ferlie & Shortell, 2001). In addition to this, the new health care worker should also bring forth all their cooperative abilities that they can possible muster in order to meet the increasing demands of collaboration, both with respect to inter-professional collaboration and intra-professional collaboration (Berwick et al., 2008; Falk & Nilsson, 1999; McLaughlin & Kaluzny, 2005; Williams et al., 2007).

In light of the above, the practice of the new health care worker appears to be one of potential conflict; conflict which may arise relation to patients, as well as to colleagues. Towards the patients, health care workers are furthermore expected to act in accordance with the demand for equality (Socialstyrelsen, 2006), but, as shown, in Paper I, II, and III, there seem to be obstacles in embracing the demand. In the separate papers, PCC, holistic care, and CM are presented as discourses which compete with, or at least affect the health care workers' ability to translate the demand for equality into practice. As stated by Kilpatrick,

Lavoie-Tremblay, Ritchie, Lamothe, and Doran (2011), all these competing interests and discourses should be clarified for health care workers, current practitioners as well as upcoming, in order for them to have any reasonable chance of delivering optimal patient care without sacrificing equality.

IMPLICATIONS FOR HEALTH CARE PRACTICE

A broader and deeper understanding of how discrimination is verbally communicated in health care practice is of great importance, if we are to achieve equal care. However, it is also of crucial importance that the organization within which the communication is embedded really advocates for and offers reasonable opportunities for health care workers to deliver equal care. As we have seen, there are several competing demands and priorities within health care organizations which create impediments for health care workers. In an era of increasing administrative control, and of decreasing professional and personal control for health care workers (Hedegaard & Ahl, 2013; Orlikowski, 1991), almost every aspect of health care delivery has been transformed into measurable indicators. Lupinacci (2010, p. 984) argues that one must only focus on the clinical aspects of health care delivery, and that aspects such as "staff courtesy, ambience and food quality" are irrelevant. But to dismiss interactions, such as interpersonal encounters, that do not directly affect the strictly clinical aspects of health care delivery would be problematic. Since overall patient satisfaction with the health care system is strongly influenced by the interpersonal treatment they receive (Schoenfelder, Klewer, & Kugler, 2010), and that discrimination, more often than not, is expressed through verbal communication, it is reasonable that this area of health care provision also be recognized. The question which

some of the results of this thesis bring to the fore is *how should discrimination be recognized*? The prevailing NPM and its associated performance discourse advocate comprehensive measurements, not only concerning the value of the care for the patients, but also "departments, physician specialties, discrete service areas, and line items such as drugs and supplies" (Porter, 2010, p. 2481). In alignment with this, national agencies have expanded the areas of operation that are covered by these measurements through "Öppna jämförelser" (Open comparisons) (Sveriges Kommuner och Landsting & Socialstyrelsen, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013), in which a variety of indicators are intended to cover the six demands that constitute *God vård* (Quality care) (Socialstyrelsen, 2006, 2009b). Furthermore, in 2013, the indicators that are linked to social positions and equal care received special attention in a separate report (Socialstyrelsen, 2013). Despite these efforts, discrimination is still measured on a superficial level. Quantitative indicators do not reveal how discrimination is enacted in practice, because these indicators fail to address interpersonal and organizational communication in any meaningful way.

Health care workers have to relate to this measuring- and evaluation-intensive environment. The struggle between the professional and administrative spheres has been previously investigated, and some researchers suggest that this struggle often promotes the *status quo* due to the equal strength between the two most powerful representatives of each sphere; the physicians and managers (Bååthe & Norbäck, 2013; Jespersen, 2005). However, with the administrative sphere's current focus on process-orientation, instead of results or aims, together with a stronger belief in cooperation (both multi-professional and cross-

organizational between professionals and administrators) where efforts are made to meet all demands, the administrative sphere risks colonizing the professional sphere. This has practical implications for the health care professional. The traditional patient work roles ('cure' for physicians, and 'care' for nurses and assistant nurses) is supplemented by organizational development work (Bååthe & Norbäck, 2013; Hood, 1995; Leonard et al., 2004). This may imply that patient encounters actually decrease, when quantifiable results are highlighted instead (Forssell & Ivarsson Westerberg, 2006; Nilsson, 2008). For instance, the fact that Sweden is one of the OECD countries with the highest number of physicians per capita, but that the number of annual visits to physicians per capita is significantly lower than the average number of annual visits in the OECD (Myndigheten för vårdanalys, 2013b), can be seen as a manifestation of such a priority.

In the spring of 2013, a large number of physicians and other health professionals signed the so-called "läkarupropet" (the physicans' petition)[16], where they expressed their concerns about the Swedish health care system. Amongst other things, they requested that they be provided opportunity to deliver care that is based on the patient's needs, that they be governed by their professionalism, and that they be allowed to dedicate themselves to what they are trained for. This claim is supported by the Swedish Agency for Health and Care Services Analysis (Myndigheten för vårdanalys, 2013b), who emphasize the fact that the current administrative burden is unreasonable, and that priorities be set regarding the value of certain administrative requirements. Thus, many health

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[16] http://upprop.nu/vvgv

care professionals have to adapt to being active in an organizational- and institutional practice where their primary tasks of curing and caring, and thereby a large part of their professional identity, faces competition from administrative tasks. The performance of these tasks, in turn, may reduce the efficiency of their health care delivery (Slockett, 2012; Wallace, Lemaire, & Ghali, 2009). This catch-22 situation, consisting of the abandonment of patient interaction in favour of administrative assignments (that tend to lead to reduced efficiency and reduced quality in care) has become inscribed in the job descriptions of professional health care workers. In addition, to question these conditions creates obstacles for health care workers, from a development and change-oriented perspective (Agarwal & Murinson, 2012; Audet et al., 2006; Bååthe & Norbäck, 2013; Porter, 2010). Since several studies have now established a correlation between health care workers' working conditions and patients' satisfaction with their health care (see, for instance, Mache, Vitzthum, Klapp, & Groneberg, 2012; Szecsenyi et al., 2011), it is now important to ensure that the professional identity of the health care worker is not lost while health care workers are turned into administrators, and while patients are expected to assist the health care worker in the delivery of care and cure.

What my four studies and this introductory chapter suggest is that the health care workers perform their duties within an organization, that, due to the rise of standardization, measurements, streamlining, and rationalization, sets a priority on administrative tasks, which reduces the time that is spent with patients and the time spent on reflecting upon one's own actions and communication as a health care worker. It has already been established that health care workers use leading questions

to make consultations more effective (Berry, 2006), and the decreased time that is allocated for patient encounters and consultations may lead to increase the health care workers' use of stereotypes and prejudices in communication with patients as a short-cut to achieve efficiency. The experiences that the administrative work intrudes on the core mission of health care ('care and cure') have been clearly been pointed out in the "läkaruppropet". Thus, these health care workers seem to have raised their awareness about themselves as being part of an institution that has created potentially discriminatory practices. They have also identified a need for organizational support in order to reverse inequality and the deterioration in the quality of their work. Health care workers have also created conditions for exploratory learning (Ellström, 2005) by developing their knowledge and competencies regarding what the organization, as well as the individuals operating in the organization, would benefit from. Hopefully, this will be heeded as organizational and health care quality improvement in the future.

IMPLICATIONS FOR EDUCATION

In the second chapter, 'Discrimination in health care' the need for improvements that reduce discrimination and increase equality was discussed in the light of governing and regulatory acts, and was supported by several examples of discrimination in health care. However, economic scarcity and changes in the political landscape also call for improvements and pervasive changes of the organizational foundation of health care. Implementation of a new structure in the organizational system of National Health Care, NPM, accompanied with scare resources, a new regulatory framework, and various new daily caring processes in a growing multi-cultural context have resulted in an increasingly complex sys-

tem for health care professionals (Myndigheten för vårdanalys, 2012; Socialstyrelsen, 2006). The first three studies included in this thesis (Paper I, Paper II, and Paper III) constitute a learning focus on communication, an area of great importance in a health care worker's formal education. The forth study (Paper IV) makes a valuable practical contribution by suggesting ways to avoid the reproduction of gender inequalities that are otherwise implied in the current organization model.

IMPLICATIONS FOR EDUCATIONAL CONTENT

Communication skills are a crucial area for various categories of health care worker who are enrolled in their education as well as for health care workers in continuing education. A governmental inquiry into a renewed health care education program has shown that certain elements of the education curriculum such as communication and interpersonal treatment needed to be further strengthened due to the increasingly popular PCC ideal (Statens offentliga utredningar (Swedish Government Official Reports), 2013). In addition, health care workers also need to demonstrate competencies within their different fields of knowledge, including public health, systems of care, quality improvement, communication skills, behavioral health care, as well as develop expertise in documentation and the taking of measurements (Myndigheten för vårdanalys, 2013b). The results of the four studies that are presented in this thesis indicate the need for development with respect to communication and other instructional elements in the education program that are directed towards all categories of health care worker, in order to make them better prepared to meet the demands of today's health care system. Specifically, health care workers (present and future) would benefit from developing a greater awareness of the gender aspects of com-

munication and how they themselves, together with their patients, contribute to create clinical differences. Furthermore, it is also important to develop knowledge and awareness of the impact that new organizational systems and their various accompanying models and tools have in practical settings and on interpersonal treatments. Understanding that communication *about* patients may, in the long-term, have as much impact as communication *with* patients, is a significant insight. The need to develop awareness, competence, and insight in these areas indicates the complexity that surrounds discrimination in health care. The more aware health care workers become of this, the better equipped they are to eliminate discrimination, and promote equal care instead.

The health care work that is accomplished by members of multidisciplinary teams puts demands on "new types of health care workers". The new type of health care worker is one "who can practice evidence-based medicine, [and] make better use of technology to deliver high-quality care" (Bacon & Newton, 2014, p. 22). They are to be able to provide PCC, work together as professionals in teams, and avoid problems when they cooperate with each other, while being exposed to the stressful demand of delivering high quality care (Axelsson, Brink, & Lötvall, 2014; Carlsson, Pettersson, Hyden, Öhlen, & Friberg, 2013). In the medical field, as in other professions in the public and private sectors, employees need a certain period of time to become adjusted to a new role, new working conditions, new values and norms, and new co-workers and management (Pennbrant, Nilsson, Öhlen, & Rudman, 2013). I agree with the results of research studies from other countries which argue that the pragmatic and ultimate solution to meet these challenges is to develop new education programs for all categories of health

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care professionals (Bray, O'Brien, Kirton, Zubairu, & Christiansen, 2014; Pershing & Fuchs, 2013).

The pragmatic aspects of the health care education program which aim to prepare the students for clinical practice should also contribute to raising the students' awareness about the conditions that they will work under, how they can influence their work situation, and the fact that their primary work function ('care and cure') at times, is likely to be experienced as a secondary work function. Incorporating multi-professional and leadership training into the health care education program are important goals, but as long as they are not seen as elements of a larger context, the learning is at risk of being limited to individual health care workers without any opportunities to change and develop the whole organization and discourse in order to provide equal care.

IMPLICATIONS FOR FORMS OF EDUCATION

Regardless of educational level, there is a need to offer education in small groups and on an individual level so as to increase awareness of the major impact that health care workers have on their patients. Forms of education should be presented that allow students, as individuals, to be influenced by the content and that allows students to experience their own shortcomings. For instance, the usage of video-recorded consultations, simulated meetings and experiments with patient encounters, together with individual feedback from both fellow students and teachers, have proven to be a popular and effective form of education (Fagerlind, Kettis, Bergstrom, Glimelius, & Ring, 2012). This applies to all categories of health care workers, regardless of educational level, as well as those engaged in staff training and continuing education. With respect to practicing health care workers, the importance of further knowledge

regarding communication and interpersonal treatment has been high-
lighted in this section and as a result, various training programs on mod-
els for standardized communication have been frequently used
(Inspektionen för vård och omsorg, 2013).

In order to create better working conditions for health care workers so
that they can communicate and respond to patients in an manner that
meets the demand for equality, it may be appropriate to incorporate
more communicative aspects in the ongoing quality improvement work
that health care workers are expected to contribute to. The efficiency
demand, which occupies a prioritized position in quality improvement
work, may advantageously be complemented with aspects such as com-
munication and interpersonal treatment that are linked to the equality
demand. The quality improvement work may, for instance, be systema-
tized by conducting some form of participatory research (Aagaard
Nielsen & Svensson, 2006; Fals-Borda & Rahman, 1991). Health care
workers could thereby participate in critical studies and get feedback on
their ability to communicate *with* patients and *about* patients who have
different social positions, including gender, ethnicity, and the ability to
communicate in Swedish. The results from the four studies that are in-
cluded in this thesis emphasize the importance of learning about com-
munication, as well as serve as a bridge between theory and practice in
formal education that is directed towards prospective- and existing
health care workers in a multicultural health care context.

LIMITATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

Many questions were raised during the time this thesis was written; questions that could not be incorporated in the limited framework employed in the thesis. Notwithstanding this limitation, there are several research questions that should be of interest and it is important that they be dealt with in the future. Ahlberg and Krantz (2006) call for research on structurally-incorporated discrimination from an organizational perspective. This thesis has largely been based on an examination of individual health care workers'-, patients'-, and health care teams' interpersonal and communicative contributions in the creation of unequal and discriminatory settings. Although the organization's role in enabling or impeding these kinds of settings has been highlighted throughout this thesis, it has been done so on strictly theoretical grounds. Further research should therefore address this subject from an empirical point of view; for example, by observing not only specific settings, such as consultations, ward rounds, and verbal handovers, but by observing and investigating the entire operation that constitutes the health care worker's total work environment. Through such studies, it would be possible to further examine, not only the organizational conditions for the health care workers as they try their best in delivering equal care, but also to provide conditions which allow for effective patient involvement.

From the patients' perspective, further and more extensive studies would be welcome, both within the cardiac patient group and in other

patient groups. The cardiac patient group has previously attracted attention because of the fact that women and men have been diagnosed and treated similarly, which resulted in negative consequences for women (Low, Thurston, & Matthews, 2010). Therefore, it would be of interest to investigate whether the gender-stereotyped communicative construction is particularly prevalent in this patient group, or if it is a general phenomenon that manifests itself in other patient groups as well. Moreover, it is also important to examine the possible existence of stereotyped- and discriminatory communication in reference to other social positions. To further explore both the extent of such communicative constructions would contribute to a more comprehensive picture of discrimination in health care.

SVENSK SAMMANFATTNING

I föreliggande svenska sammanfattning kommer avhandlingens centrala delar att presenteras i komprimerad form. Totalt består sammanfattningen av sex avsnitt, vilka är introduktion, diskriminering I hälso-och sjukvården, teoretiskt och konceptuellt ramverk, metod, resultat samt konklusion och implikationer.

INTRODUKTION

Diskriminering baserat på fördomar och stereotyper kopplade till olika sociala positioner, är ingalunda en ovanlig företeelse. Diskriminering är inte kopplat till någon specifik geografisk plats eller någon kulturell eller institutionell uttrycksform utan snarare kan det betraktas som en konsekvens av mänsklig interaktion (Abrams, 2010; Illeris, 2001; Schneider, 2004) och meningsskiljaktigheter (Johnsdotter, 2007). Forskningen inom ramarna för föreliggande avhandling, är situerad inom hälso- och sjukvården där konsekvenserna av diskriminering måhända blir än mer allvarliga. Till exempel visar detta sig i form av att tillgången till hälso- och sjukvård är ojämlikt fördelad mellan olika sociala positioner och att bristande bemötande minskar vissa patientgruppers benägenhet att söka vård (Diskrimineringsombudsmannen, 2012). Därtill föreligger det skillnader vad gäller tillgång till medicinska behandlingar (Diaz, 2009; Risberg, 2004; Risberg et al., 2009; Socialstyrelsen, 2004; Szczepura et al., 2005) och att vissa patientgrupper känner sig dåligt bemötta av hälso- och sjukvårdspersonalen (Abrums, 2004; Arber et al., 2006; Basnett, 2003;

Thornton et al., 2011; Upmark et al., 2007). Diskriminering kan dock inte enbart kopplas till individuellt beteende. Ahlberg och Krantz (2006) menar att ramverket inom vilket individer utsätter andra och själva blir utsatta för diskriminering, fastställs av den rådande organisatoriska och institutionella diskursen, vilken på olika sätt bidrager till att antingen hindra eller möjliggöra en sådan särskiljande praktik. Därför blir det viktigt att se den enskilda praktikern och/eller de olika hälsoteamen som en del av en institution, inom vilken diskriminering är strukturellt införlivat.

Mitt pedagogiska intresse medför att diskriminering kommer att analyseras från ett kommunikativt perspektiv då kommunikation i detta sammanhang förstås som ett stöd för lärande i relation till konstruerandet och utvecklandet av sociala identiteter så som de tar sig uttryck i de hälsokontexter som undersöks. Inom hälso- och sjukvården utgörs kommunikationen naturligtvis av den verbala och interpersonella konversationen (Wynia & Osborn, 2010), både mellan personal och mellan personalen och patienterna. Därutöver är kommunikationen också av central betydelse för implementeringen av policyer och managementmodeller som är konstruerade för att påverka den organisatoriska och institutionella diskursen (LeGreco & Canary, 2011). Tidigare forskning kring verbal interpersonell kommunikation och diskriminering har primärt fokuserat på kommunikationen mellan hälso- och sjukvårdspersonalen och patienterna, med betoning på de tidigares bidrag i första hand. Patienternas bidrag har i stor utsträckning förbisetts. Denna avhandling kompletterar den tidigare forskningen genom att inkludera patientens roll. Genom att kontextualisera kommunikationen in en organisatorisk och institutionaliserad diskurs,

bidrager avhandlingen med en utökad förståelse för hur diskriminerande mekanismer kommuniceras och förhandlas. Under de senaste årtiondena har svensk hälso- och sjukvård blivit alltmer influerat av New Public Management (NPM) (Hood, 1991, 1995) och det samhörande effektivitetsparadigmet (Anell et al., 2012), vilka har påverkat och påverkar de organisatoriska förutsättningarna inom hälso- och sjukvården (Abrahamsson & Johansson, 2008; Leonard et al., 2004). Även om kritiska studier förekommer har mycket av den tidigare forskningen fokuserat på effektivitetsaspekter av de olika modeller och verktyg som förespråkas i och genom dessa olika policyer (Bergmark, 2008; Magnussen et al., 2009; Williams et al., 2007). Som en konsekvens av den stora fokuseringen på effektivitet och kontroll har andra aspekter förbisetts, till exempel jämställdhet- och jämlikhetsimplikationer (Standing, 1997; Standing, 2000). Föreliggande forskning avser att fylla denna kunskap- och forskningslucka genom att undersöka två specifika institutionaliserade diskurser som är inspirerade av NPM, patient-centrerad vård (PCV) och Kliniska Mikrosystem (KM).

SYFTE

Avhandlingens övergripande syfte är att bidraga till förståelsen för hur diskriminering uttrycks i mellanmänsklig och organisatorisk kommunikation i hälso- och sjukvårdens praktik. Avhandlingen omfattar fyra artiklar med individuella syften, vilka alla är inkorporerade i det övergripande syftet. Nedan presenteras de olika studiernas individuella syften:

1 Att utforska om, och i så fall hur, patienter blir ömsesidigt verbalt konstruerade som manliga och kvinnliga patienter i

kommunikationen med hälso- och sjukvårdspersonal vid konsultationer *(Paper 1 – Kommunikativ och genusifierad konstruktion av patienter vid konsultationer).*

2   Att utforska hur patienter med och patienter utan svenska som modersmål blir verbalt konstruerade vid konsultationer med läkare och att diskutera resultaten utifrån idéen om patient-centrerad vård *(Artikel 2 - Kommunikativ konstruktion av patienter med och utan svenska som modersmål vid konsultationer).*

3   Att studera könsmönster i hur två multiprofessionella team kommunicerar om patienter i deras frånvaro (Paper III - Kommunikation om patienter i multiprofessionella team: Ett genusperspektiv).

4   Att föreslå ett teoretiskt ramverk för forskning kring jämställdhetsimplikationer av Kliniska Mikrosystem, en New Public Management-inspirerad modell för multiprofessionell samverkan och förbättring av hälso- och sjukvårdens effektivitet och resultat *(Artikel 4 – Den genusifierade undertexten av New Public Management-inspirerade arbetsmetoder i svensk hälso- och sjukvård).*

DISKRIMINERING I HÄLSO- OCH SJUKVÅRDEN

Inom svensk hälso- och sjukvård finns det mängder med lagar, föreskrifter och styrdokument, vilka ger direktiv kring vad god vård bör innebära gentemot enskilda medborgare samt anvisningar till hälso- och sjukvårdspersonal och sjukvårdsledning om hur vården bör säkras, utvecklas och organiseras. I föreskriften *God Vård* [17] (Socialstyrelsen, 2006) lyfts de mest betydelsefulla och centrala delarna från de lagar som reglerar svensk hälso- och sjukvård fram och sammanfattas i sex principer kring vad som utgör en god vård; *kunskaps- och ändamålsenlig, säker, patientfokuserad, effektiv, tidsrimlig* samt *jämlik*. Därutöver styrs hälso- och sjukvården av deklarationen om *Rätten till hälsa* (World Health Organization, 1946), vilken bland annat understryker rätten att erbjudas vård utan någon form av diskriminering.

De skriftligt formulerade rättigheterna skiljer emellertid sig från dessas praktiska tillämpningar. En genomgång av tidigare forskning kring diskriminering inom hälso- och sjukvården ger vid handen en bild av en tämligen utbredd diskriminering, i Sverige såväl som internationellt. Vad gäller de två centrala sociala positionerna i föreliggande avhandling – genus och etnicitet – indikerar svensk forskning till exempel att män ges bättre vård än kvinnor (Myndigheten för vårdanalys, 2013a; Smirthwaite, 2007) och att de erbjuds fler och mer grundliga undersökningar medan kvinnor föreslås medicin mycket tidigare i undersökningsprocessen

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[17] Denna föreskrift bygger på den amerikanska rapporten, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Committee on Quality of Health care in America, 2001).

(Risberg, 2004; Risberg, Johansson & Hamberg, 2009). Vidare har kvinnor längre väntetid vad gäller operationer (Smirthwaite, Lundström, Albrecht & Swahnberg, 2013; Sveriges Kommuner och Landsting, 2012, 2013) och skattar bemötandet från hälso- och sjukvårdspersonalen lägre än män (Socialstyrelsen, 2013; Sveriges Kommuner och Landsting, 2011, 2012, 2013; Upmark m.fl., 2007). Vad gäller personer med annat etniskt ursprung än svenskt, pekar den svenska forskningen bland annat på att de erbjuds medcinska behandlingar i mindre utsträckning än etniska svenskar (Diaz, 2009), att de känner sig mindre delaktiga i kontakten med hälso- och sjukvården (Socialstyrelsen, 2011) och mer diskriminerade (Groglopo, 2006).

Med denna forskning och kartläggning av den bristande jämlikhet inom svensk hälso- och sjukvård i ryggen, förefaller det som att det finns goda förutsättningar att förändra hälso- och sjukvården till att bli mer jämlik. Principen om en jämlik vård är dock enbart en av totalt sju principer som prioriteras och dessa principer kan stundom stå i en konkurrenssituation gentemot varandra. I Sverige har landstingens intäkter minskat de senaste åren samtidigt som deras kostnader har ökat (Ackerby m.fl., 2005; Anell m.fl., 2012; Falk & Nilsson, 1999). Detta har lett till att principen om en effektiv hälso- och sjukvård har varit överordnad de andra principerna och fler och fler landsting har därför inspirerats av New Public Management (Hood, 1991, 1995) och implementerat organisationsmodeller, såsom Kliniska Mikrosystem (KM) (Nelson, Batalden & Godfrey, 2007), med förhoppningen att dessa svarar upp mot rationaliseringsbehoven samtidigt som de också bidrager till hälso- och sjukvårdens utveckling och förbättring (Abrahamsson & Johansson, 2008; Agevall, 2005; Björk, Forsberg

Kankkunen & Bejerot, 2011; Dahlgren, 2010; Hasselblad, Bejerot & Gustafsson, 2008; Martinussen & Magnussen, 2009). Dessa modeller, genom vilka rationalisering och standardisering förespråkas, verkar således inom en organisation som samtidigt måste beakta individuell patientfokusering och leverera jämlik vård.

TEORETISK OCH KONCEPTUELLT RAMVERK

I föreliggande avhandling har ett socialkonstruktionistiskt angreppssätt (Berger & Luckmann, 1966; Burr, 2003; Weedon, 1999) använts, med vilket menas att kunskap om och förståelse för tillvaron är socialt konstruerat. Det innebär till exempel att en social position såsom genus eller etnicitet inte betraktas som något essentiellt, något som "är", utan snarare som något konstruerat, något som "blir". Teoretiskt sett kan därför genus och etnicitet "göras" på mängder med olika sätt men då konstruerandet inte enkom är en individuell process (Butler, 2004; Eagly, 2009; West & Zimmerman, 1987), påverkas konstruerandet av kulturella strukturer och normer. Som en följd av detta inrymmer såväl genus som etnicitet dikotomier, genom vilka det som betraktas som normalt skiljs från det som betraktas som onormalt. Isärhållandet mellan till exempel femininitet och maskulinitet samt svenskhet och "icke-svenskhet" syftar till att skapa över- och underordning mellan kvinnor och män samt mellan svenskar och "icke-svenskar" (Acker, 1992; de los Reyes & Kamali, 2005a; Groglopo, 2006; Hyde, 2005) genom tillskrivning av egenskaper och förmågor.

Det sociala konstruerandet av genus och etnicitet som är av intresse i föreliggande avhandling är det som sker genom kommunikation. I enlighet med Fairclough (2001) och Linell (2009), förstår jag kommunikation som ett uttryck för specifika diskurser snarare än som isolerade uttalanden. Således blir ett uttalande sammanlänkat med såväl tidigare som kommande uttalanden, vilka formar den sociala verkligheten i konstant social och språklig interaktion mellan de kommunicerande parterna. Detta ger ett dialogiskt betraktelsesätt på

kommunikationen inom vilket olika perspektiv och förståelser kan mötas.

Det kommunikativa konstruerandet av genus och etnicitet äger rum inom ramarna för en organisatorisk kontext - hälso- och sjukvården. I likhet med kommunikatoin, betraktar jag en organisation som ömsesidigt konstruerad av individer och kollektiv (Berger & Luckmann, 1966; Downing, 2005). Inom en organisation finns det dock särskilda diskurser (såsom till exempel principen om jämlik vård och NPM) som utövar inflytande på det organisatoriska konstruerandet. I enlighet med Agar (1985) menar jag att den förhärskande organisatoriska diskursen dikterar utbudet av övriga tillgängliga diskurser inom en orgnaisation. I egenskap av förhärskande organisatorisk diskurs representerar NPM en diskurs som möjliggör och värdesätter mätningar, effektivisering och rationalisering på bekostnad av kritiska tillvägagångssätt som ifrågasätter den förhärskande diskursen.

METOD

Tre av de fyra paperna i föreliggande avhandling var empiriska studier medan den fjärde var en kritisk litteraturestudie. Det empiriska underlaget bestod av 23 ljudinspelade konsultationer mellan hälso- och sjukvårdspersonal och patienter (12 konsultationer mellan sjuksköterskor och patienter samt 11 konsultationer mellan läkare och patienter) samt 30 ljudinspelade aktiviteter där multiprofessionella sammankomster ägde rum (13 ronder och 17 överrapporteringar). Konsultationerna utgjorde underlaget till paper I och II och de samlades in vid sex strategisk utvalda (Hedberg, Johanson & Cederborg, 2008) sjukhus (5 landstingssjukhus och 1 universitetssjukhus) i söda Sverige. Det gemensamma för samtliga dessa klinker var att sjuksköterskor och kardiologer träffade patienterna tre månader efter att dessa fick sin diagnos (förmaksflimmer (FF)). Den deltagande hälso-sjukvårdspersonalen utgjordes av fem sjuksköterskor och fem läkare som valdes ut av de sex klinikcheferna utifrån variation i kön, ålder och klinisk erfarenheter av kardiologi. De deltagande patienterna tillfrågades av deras respektive konsulterande sjuksköterska eller läkare och bestod av totalt 23 patienter (13 kvinnor och 10 män, varav 21 hade svenska som modersmål och 2 inte hade svenska som modersmål). För paper I användes hela materialet bestående av de 23 konsultationerna medan det i paper II enkom var konsultationerna mellan läkare och patienter som användes på grund av att det enbart var läkarkonsultationerna som ägde rum med patienter som inte hade svenska som modersmål. De multiprofessionella sammankomsterna (ronder och överrapporteringar) användes i paper III och insamlandet ägde rum vid en hjärtavdelning på ett sjukhus i södra Sverige. Deltagarna utgjordes enbart av hälso- och

sjukvårdspersonal och bestod av sjuksköterskor och läkare vid ronderna samt under- och sjuksköterskor vid överrapporteringarna.

I paper I och II användes kritisk diskursanalys (KDA) (Chouliarki & Fairclough, 1999; Fairclough, 1995, 2001) som ett verktyg för att identifiera och kategorisera kommunikativa mönster i kommunikationen mellan hälso- och sjukvårdspersonalen och patienterna. I paper II kompletterades KDA med Linells dialogiska perspektiv (2009) för att ytterligare kunna beskriva och analysera de olika kommunikativa mönstren. I paper III användes kvalitativ innehållsanalys inspirerad av Kvale (1996) och Graneheim och Lundman (2004) för att analysera den multiprofessionella kommunikationen om patienter. I paper IV analyserades teorier kring New Public Management (NPM) och Kliniska Mikrosystem (KM) utifrån ett genusperspektiv med hjälp av teorier kring organisatorisk kontroll i syfte att kunna föreslå ett teoretiskt ramverk för att beforska jämställdhetsimplikationer av KM.

RESULTAT

Nedan sammanfattas resultaten från de fyra papren.

KOMMUNIKATIV OCH GENUSIFIERAD KONSTRUKTION AV PATIENTER VID KONSULTATIONER (PAPER I)

Det sätt på vilket manliga och kvinnliga patienter beskrev sig själva och sina åkommor var analogt med hur hälso- och sjukvårdspersonalen besvarade och ställde frågor till patienterna. I diskursen som var mest tillgänglig för de manliga patienterna beskrev dessa sig själv och sina åkommor främst med hjälp av fysiska aktiviteter, att de till exempel var kapabla att utföra diverse fysiska aktiviteter trots sin FF. I diskursen som var mest tillgänglig för de kvinnliga patienterna var det istället emotioner som åberopades när dessa beskrev sig själva och sina åkommor. I diskursen som var mest tillgänglig vid konsultationerna med de manliga patienterna utmärktes svaren och frågorna från hälso- och sjukvårdspersonalen främst av lugnande uttalanden och positiva ledande frågor. I diskursen som var mest tillgänglig vid konsultationerna med de kvinnliga patienterna utmärktes svaren och frågorna från hälso- och sjukvårdspersonalen snarare av dramatiska uttalanden och negativa ledande frågor. När konsultationerna sedermera summerades och avslutades, var det vanligt förekommande att det inte uttrycktes någon oro gällande de manliga patienternas hälsa, vare sig av hälso- och sjukvårdspersonalen eller patienterna själva. Däremot uttryckte såväl hälso- och sjukvårdspersonalen som patienterna själva en oro för hälsotillståndet när konsultationerna med de kvinnliga patienterna summerades och avslutades.

KOMMUNIKATIV KONSTRUKTION AV PATIENTER MED OCH UTAN SVENSKA SOM MODERSMÅL VID KONSULTATIONER (PAPER II)

När patienterna intog en icke-foglig och deltagande roll utmärktes konsultationerna primärt av monologer mellan patienterna och läkarna. Detta visade sig tydligt i diskursen som var mest tillgänglig för patienterna utan svenska som modersmål (PUSSM), där dessa yttrade missnöje, krav och förslag på specifika behandlingar samt deras förväntningar kring vad konsultationerna skulle leda till. Detta möttes av argumentation från läkarna innehållande ifrågasättanden av patienternas synpunkter. När konsultationerna summerades och avslutades, konstaterades att PUSSM inte behövde någon ytterligare eller specialiserad form av vård. I diskursen som var mest tillgänglig för patienterna med svenska som modersmål (PMSSM), uttrycktes främst tacksamhet mot hälso- och sjukvården och samtycke gentemot läkarna. Detta möttes av erkännande och bekräftelse av patienternas uttalanden från läkarnas sida. När konsultationerna summerades och avslutades, konstaterades att PMSSM var i behov av ytterligare och specialiserad vård.

KOMMUNIKATION OM PATIENTER I MULTIPROFESSIONELLA TEAM: ETT GENUSPERSPEKTIV (PAPER III)

När patienterna uppfattades som att de agerade i enlighet med socialt accepterade genusnormer, utmärktes kommunikationen inom de multiprofessionella teamen av professionalitet. Detta innebar att de olika uttalandena primärt kretsade kring medicinskt innehåll och att det icke-medicinska innehåll (till exempel sociala aspekter) som ändå nämndes inte värderade av hälso- och sjukvårdspersonalen. När

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patienterna uppfattades som att de inte agerade i enlighet med socialt accepterade genusnormer, utmärktes kommunikationen inom de multiprofessionella teamen istället av informalitet. Detta innebar att det icke-medicinska innehållet (de sociala aspekterna) fick större utrymme och att det dessutom värderades negativt.

DEN GENUSIFIERADE UNDERTEXTEN AV NEW PUBLIC MANAGEMENT-INSPIRERADE ARBETSMETODER I SVENSK HÄLSO- OCH SJUKVÅRD (PAPER IV)

Genom Kliniska Mikrosystem (KM) fokuseras inte enbart målet om God Vård, utan också arbetsprocesserna associerade med tillhandahållandet av en sådan vård. Detta fokus på arbetsprocesserna kräver att det arbete som hälso- och sjukvårdspersonalen utför mäts och övervakas, vilket innebär en inskränkning av deras professionella och personliga kontroll. Istället ökar den administrativa systemkontrollen, vilket medför att hälso- och sjukvårdspersonalens inflytande över deras arbete minskar. I enlighet med New Public Management (NPM) är organisationsstrukturerna och kontrollincitamenten av mer informell karaktär, till exempel genom förespråkandet av organisatorisk konsensus där all hälso- och sjukvårdspersonal förväntas sträva mot samma mål och multiprofessionella samarbeten frodas. Därmed föreskrivs specifika ageranden från hälso- och sjukvårdspersonalens sida, såsom att vara samarbetsvillig och flexibel för att uppnå inflytande. När informella kompetenser såsom beteendemässiga och sociala färdigheter, inkorporeras i arbetsbeskrivningar tenderar det att gynna de med den formella makten. Således riskerar multiprofessionella samarbeten att bli samarbeten på ojämlika villkor och reproducera snarare än utmana den rådande genusordningen.

KONKLUSION OCH IMPLIKATIONER

De fyra paprena har gett vid handen att diskriminering inom hälso- och sjukvården utmärks av kommunikation bestående av såväl ömsesidigt reproducerade (mellan hälso- och sjukvårdspersonal och patienter) stereotyper kring genus och etnicitet som motsättningar kring, och nedvärderande kommentarer riktade mot, patienter som uttryckte och/eller uppfattades som att de inte agerade i enlighet med socialt accepterade genusnormer. Genusdiskrimineringen kan förstås som de genusstereotyper som uttrycktes kommunikativt i de kontexter som undersöktes genom de tre empiriska studierna. Dessa stereotyper förmedlades fram och tillbaka mellan de kommunicerande parterna. Gällande etnisk diskriminering framstod det inte som att de etniska stereotyperna uttrycktes kommunikativt och explicit utan snarare påverkade de olika diskurser till att tillgängliggöras för de kommunicerande parterna. Därutöver har de fyra paprena ävenledes bidragit till att utvidga förståelsen för hur den organisatoriska och institutionella diskursen påverkar de kommunikativa förutsättningarna samt möjligheterna att möta kraven om en jämlik vård.

Att nå en djupare förståelse för hur diskriminering uttrycks kommunikativt inom hälso- och sjukvården, är en förutsättningar för att kunna erbjuda en jämlik vård. Det är dock avgörande att organisationen inom vilken kommunikationen äger rum verkligen förespråkar och skapar rimliga förutsättningar för hälso- och sjukvårdspersonalen att ombesörja detta. Hälso- och sjukvårdspersonalen verkar i en mätnings- och utvärderingsintensiv miljö där deras primära arbetsuppgifter att vårda och bota utsätts för konkurrens, vilket föranlett protester i form av läkarupropet. Således tycks hälso- och sjukvårdspersonalen ha en

medvetenhet kring dem själva som del i en institution som skapar potentiella diskriminerande praktiker och de har identifierat behovet av organisatoriskt stöd för att kunna säkerställa jämlik vård och vända kvalitetsförsämringen i deras arbete. Förhoppningsvis betraktas detta som en viktig del i hälso- och sjukvårdens organisatoriska och vårdgivande kvalitetsförbättring i framtiden.

De kommunikativa färdigheterna är viktig kompetens att utveckla för samtliga kategorier av hälso- och sjukvårdspersonal och resultaten från de fyra paprena tyder på att det finns kompetensbehov att fylla därvidlag. Såväl framtida som nuvarande hälso- och sjukvårdspersonal vore betjänta av att utveckla en större medvetenhet för genusaspekter i kommunikation och hur de själva, tillsammans med patienterna, bidrager till att skapa kliniska skillnader mellan könen. Vidare är det även viktigt för dem att utveckla kunskap och förståelse för hur nya organisationssystem och tillhörande managementmodeller påverkar de praktiska förutsättningarna och mellanmänskliga bemötanden. Därutöver behövs en insikt om att kommunikation om patienter mycket väl, i förlängningen, kan påverka den professionella kulturen och identiteten lika mycket som kommunikationen med patienter.

Oavsett yrkeskategori och utbildningsnivå, föreligger ett behov av att erbjuda utbildning i mindre grupper och på individuell nivå som möjliggör en ökad medvetenhet kring den stora inverkan hälso- och sjukvårdspersonal har på sina patienter. Utbildningsformerna bör möjliggöra för de lärande att bli påverkade av innehållet och erfara deras egna tillkortakommanden i syfte att kunna utvecklas i sitt yrkesutövande.

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The Production and Maintenance of Inequalities in Health Care
A communicative perspective

JOEL HEDEGAARD

The Swedish health care system does not offer equal care and discrimination in the form of substandard communication toward female and foreign-born patients are common. Health care is also under pressure to increase efficiency and quality of care, which increases the risk that equality will be pushed aside. In this thesis, interpersonal- and organizational communication are explored in four studies in order to contribute to our understanding of how discrimination is expressed, and subsequently to highlight educational implications for health care practices. In the first study, critical discourse analysis (CDA) is used to categorize gender patterns in communication between health care workers and patients, and finds that both parts reciprocally reproduce the gender order. Open questions create a setting less prone to be limited by gender stereotypes. In the second study, CDA is used and complemented with a dialogic perspective in order to explore whether native and non-native Swedish speaking patients were constructed differently in patient-physician consultations. Findings indicate that although the non-native speakers were model, participative patients according to patient-centered care, they were met by argumentation, whereas the more amenable native patients were met by accommodating responses. In the third study, qualitative content analysis is used to analyze how health care workers talked about patients in their absence. The results reveal that communication about patients who were perceived as not acting according to socially accepted gender norms contained disparaging statements. The final study focuses on Clinical Microsystems. Drawing on theories of New Public Management, gender, and organizational control, the findings indicate that the construction of innovative and flexible health care workers risks reproducing the gender order. This thesis concludes that gender and ethnic stereotypes are reproduced in health care communication, and that an efficiency-inspired organizational and institutional discourse may be an impediment to equal care. This calls for focus on learning about communication for prospective and existing health care workers in a multicultural health care context.