Trusting and distrusting in dialogue: A study of authentic medical consultations

Jens Allwood, Nataliya Berbyuk-Lindström and Inga-Lill Johansson

Abstract: The purpose of this chapter is to contribute to the understanding of trusting as a dynamic relational process that can vary with circumstances. Based on an analysis of a number of physician–patient consultations in a Swedish hospital, we show how consultations lead to increased trust or decreased trust and in some situations have no apparent effect. The consultations, and the accounts given in them, can lead to trusting if they correspond to the uncertainty or needs that the other party expresses, assuming willingness to collaborate and cooperate. However, counteracting distrust (perhaps using accounts) is complicated, especially when this unexpectedly becomes necessary in ongoing interaction.

Purpose

In this chapter, we will illustrate how trusting and distrusting are expressed in dialogue in a Swedish organizational context – public health care. In doing so, we will point to the enactment of accountability as a critical aspect of establishing and maintaining or not maintaining trust relationships. Specifically, we will analyse and discuss how the requesting and giving of accounts influence trusting and distrusting with the purpose of contributing to the understanding of trusting as a dynamic relational process that can vary with circumstances.

Trust can be built or lost through experience. Our trusting or distrusting of another person depends on our evaluation of the actual actions and accounts of actions given by this person and/or other persons. Accounts provide an opportunity to assess the extent to which the actions of a person are understandable and acceptable with regard to different criteria, such as legal, financial, ethical and so on. Accounts can be understandable and believable without, for example, being ethically acceptable. Thus, besides performing acceptable actions, giving acceptable accounts of our actions is a way in which we can make other persons trust us, avoid potential distrust and even counteract manifest distrust. Conversely, non-acceptable actions and non-acceptable accounts can lead to distrust.

Though accounts are instruments for repairing distrust and building trust, there is no guarantee that an accepted account will increase trust, as successfully meeting the requirements of accountability may not be sufficient for this. However, if we do trust another person, it probably holds that he/she has provided acceptable actions and accounts regarding the aspects of behaviour that we trust. An empirical question for us concerns the role of provided accounts in situations in which earlier experiences of interlocutors create uncertainty for account recipients about the expected positive/optimal function of current actions by the account giver. Does the account lead to increased or decreased trust or is it irrelevant?

Background and review

Many definitions have been given of trust; a fairly representative definition is provided by Khodyakov:

> Trust is a process of constant imaginative anticipation of the reliability of the other party's actions based on (1) the reputation of the partner and the actor, (2) the evaluation of current circumstances of action, (3) assumptions about the partner's actions, and (4) the belief in the honesty and morality of the other side. (Khodyakov, 2007:p.126)

To be able to grasp the interactional and dialogical dimensions of trusting/distrusting, we turn to Möllering (2001, 2006, 2013). Inspired by Simmel, Möllering suggests that trust processes involve three elements: *interpretation* of experiences, which gives "good reasons" to trust (distrust) and *suspension* of doubt about the expected effects of earlier actions, which enables the movement from interpretation to *expectation*, the final stage of the process. Suspension of doubt and *a leap of faith* are considered to be characteristic aspects of trust.

We combine Möllering's view of trust processes with the following definition of trust (Allwood, 2014:p.193):

> Trust = socio-emotional epistemic attitude involving belief/faith/reliance in the expected positive/optimal function/behaviour of whom/what is trusted.

This gives us an understanding of both the process and the function of trust. The process can be studied by considering how the different aspects of trust suggested by Allwood (2014) vary in interpersonal relationships.

(1) Basic trust, that is, reliance on interlocutors having normal perception, understanding and linguistic competence.

(2) Collaborative trust, that is, a belief that interlocutors will adopt and collaborate toward a joint purpose.

(3) Cooperative trust, that is, the belief that interlocutors will take you into ethical consideration.[1]

(4) Trust with respect to commitments and obligations.

(5) Trust with respect to competence, that is, the interlocutor's specific competence in a particular area, for example medicine, law or economics.

The functions of trust can be brought out by comparing our definition with the definition of Khodyakov. As can be seen, our definition is similar to Khodyakov's, but it is broader and more precise. We have "belief in the expected positive/optimal function/behaviour of whom/what is trusted", whereas Khodyakov has "imaginative anticipation of the reliability of the other party's actions". Our definition is also more precise regarding the features of interaction influencing trust; we have five such features or aspects, whereas Khodyakov really only has one, namely "the belief in the honesty and morality of the other side".

Our definitions of trust and of the different aspects of trust thus provide a basis for both a static and a dynamic understanding of trust (trusting), involving trust as a process that can both increase and decrease in strength and extent in relation to the five aspects distinguished. In this way, trust (trusting) is seen as a dynamic relation, that is, a process

[1] This involves behaviour in accordance with the so-called "golden rule", with specific consequences such as do not hurt – give pleasure; do not coerce/force – give freedom; do not lie/mislead – give correct information.

that can vary with circumstances. The static side of trust is given by the definition of trust: *socio-emotional epistemic attitude involving belief/faith/reliance in the expected positive/optimal function/behaviour of whom/what is trusted*. This holds true independently of the strength and extent of the trusting relation. If there is no element of "belief/faith/reliance in the expected positive/optimal function/behaviour of whom/what is trusted", there is no trust.

According to Scott and Lyman (1968:p.46), an account is "a statement made by a social actor to explain unanticipated or untoward behavior – whether that behavior is his own or that of others, and whether the proximate cause for the statement arises from the actor himself or from someone else". However, accountability and accounts may be viewed as phenomena with a much wider scope. According to Garfinkel (1967/1984:p.2), accounts of everyday activities are used as "prescriptions with which to locate, to identify, to analyze, to classify, to make recognizable, or to find one's way around in comparable occasions". This implies that accounts are expected from all of us continuously, in all parts of our lives, private as well as professional. Thus, being a patient may involve requests for accounts ("Have you taken your medication according to the instructions?") and requests from patients for accounts from care professionals ("Why do I have to take this medication?"). Being a professional involves being exposed to requests for accounts from beneficiaries (like patients) and from managers, authorities and so on.

To support our analysis of the relation between accountability and trust, we will assume the following definitions of *accounting for (giving an account for)* and *accountability* (Allwood et al, 2015):

> Account for = report, describe in a comprehensible and acceptable way.
>
> Accountability = reification of the ability and obligation to give an account, often combined with expectations/assumptions concerning account giving, encompassing reporting and explaining actions.

The concept of "accountability" as distinct from "account" thus includes expectations/assumptions concerning account giving that nearly always involve expectations about socially acceptable behaviour and responsibility. Satisfying such expectations is often crucial for whether a person is trusted or not.

Health care consultation is a type of a social activity that often involves an asymmetrical power relationship. A patient often does not possess enough knowledge about medicine and has few options but to trust the physician's medical knowledge and professional skills to solve health problems (trust with respect to competence mentioned above). "Patients tend to think of their doctors as nearly godlike in their capabilities and loyalty to patients" (Hill & O'Hara, 2005:p.1723), and we could view their beliefs as "overtrusting" in the sense that doctors are human too. The trust of patients in their physicians probably normally implies all the aspects of trust distinguished above, that is, basic, collaborative, cooperative trust combined with reliance on the physician's commitments and competence. This means that the patient believes that the physician will understand, take care of and help him/her and treat him/her with fairness, justice,

consistency, reliability and competence. If the physician does not live up to these requirements, for example regarding competence or reliability, distrust may start to develop and be expressed by a patient holding the physician accountable for treatments. As physicians have come to expect trust from patients as a default condition, any demands for accounts from patients may be perceived as questioning their competence. Health care researchers have for some time called for more research on the new relationships between patients and physicians (and other care professionals) to increase the knowledge about the role of trust (see e.g. Rowe & Calnan, 2006; Skirbekk et al, 2011).

Method

In this section, we present our empirical studies and methods for analysis.

Our data consist of video-recorded and transcribed interactions – physician–patient consultations in a Swedish hospital (surgery). The illustrations in this chapter consist of 22 minutes of recording time. The recordings were made after obtaining written consent from everyone involved. The consent form presented the purpose of the study, the data collection, confidentiality issues and the possibility to withdraw from participation at any time as well as information about the benefits and risks involved. No researcher was present during the recordings.

In operationalizing trusting behaviour, we were inspired by Möllering, who suggests that *suspension of doubt* can be identified empirically by the use of words like "everything will be fine", "no need to worry" or "just go ahead" (Möllering,

2001:p.414) or by words indicating ambivalence, due to an understanding of one's own vulnerability, like "despite", "although", "as if" and "nevertheless" (Möllering, 2006:p.6). The opposite, *no suspension*, is assumed to be expressed explicitly by questions, demands for information and so on. In both cases, what is implicitly communicated needs to be taken into consideration since the role of the implicit (cf. Skirbekk, 2009; Skirbekk et al, 2011) is assumed to be more important in displaying trust and distrust than in displaying other socio-emotional epistemic attitudes, for example happiness or irritation (see also Grossen & Salazar Orvig, 2014).

Jokinen and Allwood (2010) suggest that cues to uncertainty (and similar phenomena such as hesitation, doubt, lack of knowledge and ignorance) may be found for example in body gestures like shoulder shrugging, which can, however, have different interpretations in different cultural contexts. Any empirical analysis of how trusting is displayed in dialogue thus requires multimodal dimensions of communication to be taken into consideration (such as prosody/phonology, vocabulary, grammar, facial gestures, manual gestures, body movements and posture). Interestingly, facial cues have been found to be superior to acoustic cues in trustworthiness information (cf. Tsankova et al, 2013). The validity of the analysis of trusting behaviour may be enhanced by self-confrontation playback interviews during which explanations of behaviour involving the interpretation of the experiences as well as the expectations created are given by the recorded parties. Due to limitations of time and resources, we were only able to annotate a subset of these features. This means, for example, that we were not able to annotate prosody and communicative gestures. The conventions used for the transcription of the recordings are shown in Table 1.

In line with Garfinkel (1967/1984), we investigated the role of accountability and accounts in trusting (distrusting) by identifying sequences in the dialogues that implicitly or explicitly could challenge what is taken for granted by the interacting parties. A challenge is something that may have serious consequences for immediate and future cooperation (cf. Flanagan, 1954 on the critical incident technique). For our purposes, we identified communicative features whereby demanding or giving accounts can be related to such challenges.

In the following section, we will present two illustrations from health care, each one with the analysis interwoven, and a summary of the findings. In the excerpts, we will comment on mood when it is possible to identify it in the recordings.

Symbol	Explanation
P, D, F, D	Participants (e.g. patient, physician)
[ ]	Overlap brackets; numbers used to indicate the overlapped parts
( )	Transcriber's uncertain interpretation of what is being said (e.g. pritsche)
/, //, ///	A short, intermediate and long pause, respectively
+	An incomplete word, a pause within a word
CAPITALS	Contrastive stress
:	Lengthening
< >, @ < >	Comments about non-verbal behaviour, comments on standard orthography, other actions, clarifications, intonation

Table 1. Transcription conventions

Trusting and distrusting in medical consultations

In this section, we will see how trusting and distrusting are shown between people who do not know each other very well – two different patients meeting their physicians for a check-up. The material is taken from a previous investigation of the influence of cultural differences on communication in health care (cf. Berbyuk-Lindström, 2008). The choice of example depends on what was available in the material and is incidental concerning the ethnicity of the physician.

Illustration I. Patient trusting physician?

A Swedish female cancer patient is meeting a female Iranian physician for a check-up. The physician asks her about the side effects of the treatment. The patient replies that she is experiencing no side effects and mentions that she is worried about this:

Excerpt 1

D = doctor (physician)

P = patient

Original (Swedish)	English Translation
D1: nähä inga biverkningar [1 elle nånting annat]1 / inga [2 andra besvär]2	D1: No really no side effects [1 or anything else]1 / no [2 other problems]2
P1: [1 nä / inte va ja vet]1	P1: [1 no / not that I know of]1
D2: [2 nä]2	D2: [2 no]2
D3: magen sköte sej [3 väl å]3	D3: Stomach is [3 fine and]3
P2: [3 ja]3	P2: [3 yes]3
D4: inga illamående [4 å]4	D4: No nausea [4 or]4

P4: [4 nä]4 nä nåt // annat < ska de vara så >	P4: [4 No]4 no // something else < should it be like that >
@ < mood: worried, intonation: rising >	
D5: < ja: de e ju / > klart att de e så	D5: < Yeah it is of course >/ it is so
@ < mood: hesitant >	
P5: jo för att eh / e / ja / ja // ja ha den uppfattningen liksom att / ju sämre man mår efteråt < > ju bättre verkan ha de	P5: Well because eh / eh / I / I // have this belief like that the worse you feel afterwards < > the better effect it has
@ < after the treatment >	
D6: ja de e den gamla uppfattningen // många patienter tror dä å tidiare många läkare också trodde att de de skulle vara så / men de e inte /	D6: Well that is the old view // many patients believe in it and earlier many physicians also believed that it should be like that / but it is not
P6: < de har [5 ingen betydelse]5 >	P6: < It does not [5 matter]5 >
@ < intonation: rising >	
D7: [5 nä]5 de e bara biverkningar som man får av re så att slippe man biverkningar så e de dess bättre	D7: [5 No]5 / it is only side effects you get from it so if you can escape side effects it is better
P7: ja ha faktist inte känt nånting däremot så fick ja en väldi hosta	P7: Actually I have not felt anything but I have got a formidable cough

The physician asks the patient about any side effects of her cancer treatment (D1–D3) and the patient reports experiencing none (P1–P4). The patient indirectly expresses worries: "should it be like that?" (P4). The hesitant tone of the physician (D5) indicates her difficulties in responding. It may be related to her Swedish language competence, that is, difficulties in understanding the patient or expressing herself. Noticing the physician's hesitation, the patient explains that she believes that "the worse you feel afterwards the better effect it has" (P5). The patient voices a view concerning the effects

of treatment that she implicitly wants to be evaluated by the physician. The physician provides this evaluation: "that is the old view" (D6) and "if you can escape side effects it is better" (D7). However, the patient continues to express worries by eliciting confirmation of her conclusion – "it does not matter" (P6) – and bringing up new symptoms – "I have got a formidable cough" (P7). Later in the interaction, the physician claims that the coughing is not a side effect. At the end of the consultation, the patient returns to the discussion of her concerns:

Excerpt 2

Original (Swedish)	**English Translation**
P1: mm de e ju den hä ständia oron liksom att // om de försvinner eller om de kan hållas i schack förstå du va ja menar	P1: Mm it is this constant worry somehow // if it disappears or if it can be kept under control do you understand what I mean
D1: mm // vi / vi ska försöka göra de bästa vi kan // förstås // e så att e / de va de här förhöjda // tumörmarkören som vi hade // [1 så att]1 de ///	D1: Mm // we / we will try to do the best we can //of course // eh so that / it was those increased tumour markers // which we had // [1 so that they]1 ///
P2: [1 mm]1	P2: [1 mm]1
P3: tycker att de e så konstit att ja kan må så bra å ändå vara sjuk / < förstå du va ja menar >	P3: Think it is strange that I can feel so good and still be ill / < do you understand what I mean >
@ < intonation: rising >	
D2: m / m / m // ä / ja: men e/ de e / de e ju / de här själva de här tumören de / de kan va en / (allså) bara en sån liten börda va så att de/ man man kan aldri säga att att / att att vi / aldri kan bota dej men de / ja ja sa att att	D2: m / m / m // er / yeah: but er / it is / it is well / this this tumour itself / it can be / (only) such a small burden so that / one can never say / that that we / can never cure you/ I I said that that the chance to

att chansen för å kunna bota minskar ju ju fler behanlingar vi ha gett å så va / [2 men]2 e de e inte noll < fårstås > så så att de/ vi försöke så gott vi [3 kan så]3 få vi se	be able to cure decreases the more treatments we have given / [2 but]2 er it is not zero < of course > so so because / we try the best we [3 can]3 so we will see
@ < förstås >	
P4: [3 m]3	P4: [3 m]3

The patient is explicit about her worries concerning the treatment. She wants to know whether the tumour "disappears or if it can be kept under control" (P1) and attempts to make this clear to the physician by twice seeking confirmation from the physician that her worries have been understood: "do you understand what I mean?" (P1, P2). One reason could be that she is not satisfied with the physician's evaluation in Excerpt 1 (D6, D7). Another reason could be difficulties in accepting the message from the physician or a suspicion about the physician having problems understanding her. The physician provides responses such as "we will try to do the best we can of course" (D1) and "I said that that the chance to be able to cure decreases the more treatments we have given it is not zero of course" (D2) ,which indicates the seriousness of the situation. Later in the interaction, the physician and the patient are planning the treatment:

Excerpt 3

Original (Swedish)	**English Translation**
D1: då så då då ska vi ge behandlingen i samma e dos som förra gången // [1 så]1 ska du inte vara orolig att att du inte ha du inte biverkningar så att de inte ska hjälpa / de gör de / lika / mycke	D1: Well then we will give the treatment in the same dose as last time // [1 then]1 you should not be worried about having no side effects that it won't help / it will / just as much

P1: [1 jaha]1	P1: [1 I see]1
P2: de gö de	P2: It will
D2: ja	D2: Yes

The physician explains that “we will give the treatment in the same dose as last time” and again assures the patient that “you shouldn’t be worried about having no side effects that it won’t help it will do just as much” (D1). The patient does not seem convinced when she responds “It will” (P2).

When the patient reveals that she suspects that the physician does not understand her, this illustrates a potential lack of basic trust in the physician’s Swedish language competence, which may influence the physician’s understanding of what the patient says. At the same time, it illustrates a potential lack of trust concerning the physician’s collaboration in establishing joint understanding. It is difficult to say whether the patient has a lack of trust in the physician’s cooperation or in the commitments and obligations of the physician. The patient does not explicitly question the efforts of the physician and the other care professionals, but continues to be worried, which may indicate a certain lack of trust in the physician’s professional competence. There is research showing that some Swedish patients are suspicious and lack trust in the professional competence of physicians educated outside the EU/EEA (cf. Berbyuk Lindström, 2008). In any case, the patient’s worries do not seem to have been suspended, perhaps related to an insight that she may die. There are no clear indications of trust or distrust in the patient from the side of the physician.

We conclude that it is difficult to decide whether this situation can be seen as an illustration of the processes of trusting or distrusting. The patient seems to accept the physician's accounts and agrees to continue the treatment at the end of the interaction. This could indicate trusting but can also be seen as a more or less polite acceptance without any relevance to trusting or, if reluctant, indicating distrusting. The excerpts illustrate that accounts are crucial communicative instruments in influencing the trust process. The accounts need to be comprehensible, clear, confirmative and at the same time considerate, respectful and truthful. Balancing these requirements demands a lot from the physician, even more so when cultural differences are involved.

Illustration II. Patient distrusting the physician and vice versa

A middle-aged Swedish male patient comes to see a middle-aged male Iranian surgeon who has treated him before. The patient has a bullet in his shoulder and is in constant pain. He believes that the bullet has split into small fragments, causing the symptoms.

Excerpt 4

Original (Swedish)	**English Translation**
D1: per-oskar / vi känner varandra och e vi har ju behandlat dej på avdelningen och e ja vet allting om dej då	D1: Per-Oskar / we know each other and eh we've treated you and eh I know everything about you then
P1: < jaha >	P1: < Is that so >
@ < mood: sceptical >	
D2: så ja vill gärna veta hur du mår ida	D2: I would like to know how you feel today
P2: ja mår inte bra	P2: I do not feel well

The physician starts by stating, “I know everything about you” (D1), to which the patient replies sceptically, “is that so” (P1), indicating that he doubts that the physician knows everything and that there may be a problem concerning trust from the very beginning. The consultation continues, and after asking a number of questions and conducting a physical examination, the physician concludes that an X-ray and a consultation with an orthopaedist are needed to evaluate the problem better. However, the patient insists on removing the bullet immediately, claiming that he has had four X-rays already and that he sees any delay in removing the bullet as unnecessary and unacceptable. In Excerpt 5, the patient argues that the Swedish Poisons Information Center informed him that it is dangerous to have a bullet in the body due to an increased risk of lead poisoning:

Excerpt 5

Original (Swedish)	**English Translation**
P1: så kan de gå väldit fort sa dom på giftcentralen till mej	P1: It can develop very fast they told me at the Poisons Information Center
D1: m [1 nej nej nej]1 de e ju dom har fel [2 de e]2 inte hundra procent på de sättet va	D1: No [1 no no no]1 it is they you know are wrong [2 it is]2 not a hundred percent in that way right
P2: [1 (...)]1 P3: [2 jaha]2	P2: [1 (...)]1 P3: [2 is that so]2

The patient implicitly criticizes the surgeon, by referring to another authority, when he says, “It can develop very fast they told me at the Poisons Information Center” (P1). The physician takes up the challenge from the patient by claiming, “it is they you know are wrong” (D1). Again, the patient responds with “is that so” (P3), which is a sign of

disbelief in the physician. The mere fact that the patient turned to the Swedish Poisons Information Center to ask for information indicates a potential lack of trust in the physician, since the physician has not provided him with the information about the risk. The physician then continues by explaining the actions to be taken:

Excerpt 6

Original (Swedish)	English Translation
D1: då gör vi så per-oskar ja kommer skriva remissen prata me dom å sen så vi kollar de här om vi	D1: Then we will do it like this Per-Oskar I will write a referral talk to them and we check this if we
P1: ja å ganska omgående för att ja vet att de de tjuåttonde december [1 (…) det ja]1 // å (...) ja ja skulle vart här för	P1: Yes and fairly promptly because I know that it is December twenty-eighth [1 (..) it yes]1 // and (…) I should have been here for
D2: [1 m]1	D2: [1 m]1
D3: ja har ju tat ut kulan på folk efter tre år utan någon liksom problem	D3: You know I have removed the bullet from people after three years without any like problems
P3: ja men då har de vart helkapslade å så inkapslade så att	P3: Yes but then they have been totally enclosed and so encapsulated that
D4: att de e ju de finns ju såna saker de finns ju men e vi sätter igång så snart som möjlit jättebra ja tittar en gång till på bilderna själv	D4: There are things like that you know there are but we start as soon as possible very good I will look at the pictures once more myself
P4: ja	P4: Yes

The physician attempts to convince the patient by referring to his professional experience: “I removed the bullet from people after three years without any like problems” (D3). The patient argues that the bullets “have been totally enclosed” (P3).

The surgeon explains that he will start the procedure as soon as possible and states, "I will look at the pictures once more myself" (D4). After the patient has requested copies of his X-rays and has insisted on being hospitalized directly, the physician says:

Excerpt 7

Original (Swedish)	**English Translation**
D1: per-oskar de går inte de e så här inte fungerar hälsovården // de är ju inte så att du kommer å säger att ja vill bli inlagd va / de e ju de e ju vi som ska bedöma om du litar på oss arbetar som doktor ja säger att de bästa för dej de e ju som ja gör va // men om du vill liksom påverka själv // då de en helt annan sak ja förstår att du har ont / [1 de]1 e därför ja reagerar annars skulle 2[(...)]2	D1: Per-oskar it does not work it's like this health care does not function // you know it's not like you come and say that I want to be hospitalized right / you know you know we are the ones who should judge if you trust us working as physician I say that the best for you it's of course what I do right // but if you want to kind of influence yourself // then it's a quite different thing I understand that you're in pain / [1 that is] 1 why I react otherwise I would 2[(...)]2
P1: [1 ja]1	P1: [1 yeah]1
P2: [2 jo jo]2 ja fattar vidden att // varför ja ska hållas (...) nu // du har konstaterat att ja har kula i axeln / så va e problemet skär bort den å ta bort den	P2: [2 well well]2 I understand the extent that // why I should be kept (...) now // you have determined that I have a bullet in my shoulder / so what's the problem, cut it out and remove it
D2: e lyssna på mej // vi röntgar dej / vi pratar me ortopeden / sen vi diskuterar va vi ska göra // fortsätt me den här medicineringen tills du kommer till ortopeden // okej	D2: E listen to me // we X-ray you / we talk to the orthopaedist / then we discuss what we should do // continue with this medication until you get to the orthopaedist / / okay

P3: a hur lång tid tar detta då	P3: How long will this take
D3: e ja vet inte // vi försöker och agera den som ska göras så snart som möjlit	D3: Eh I do not know // we will try to act what needs to be done as soon as possible
P4: ja	P4: Yeah

Again, the physician attempts to use his position of authority to claim trust: "we are the ones who should judge if you trust us working as physician" (D1) to persuade the patient. The response from the patient – "so what's the problem, cut it out and remove it" (P2) – shows that the argument apparently does not have any effect. The physician tries to calm (and thereby rebuild trust in) the patient by describing the actions to be taken by health care professionals, including himself: "we X-ray you we talk to the orthopaedist" (D2). The patient continues to be worried about the delay and asks "how long will this take" (P3). Realizing that the patient disagrees with his suggestions, the physician's patience seems to be strained:

Excerpt 8

Original (Swedish)	**English Translation**
D1: du vill inte bli påtittad utav en ortoped du vill [1 inte]1	D1: You do not want the orthopaedic surgeon to check you you [1 don't]1
P1: [1 ortoped]1 titta på mej alla tittar på mej ja har blivit röntgad å röntgad å röntgad / så att e	P1: [1 Orthopaedic surgeon]1 looks at me all look at me I have been X-rayed and X-rayed / so that er
D2: kanske behöver ingen röntgen kan skicka liksom kan referera den här röntgen du har gjort å dom ska titta å bedöma det igen då // men frågan e ju	D2: Maybe do not need X-ray can send and can reference this X-ray you've done and they will look at and judge it again then / / but the question is that

att om dom här kulorna dom här fragmenten har flyttat på sej // har dom fastnat i nån muskulatur har dom kommit nära leden [2 de]2 e massor av saker ska man tänka å du tänker inte på såna saker // å tyvärr ja har inte tid å liksom diskutera så här va MEN låt oss // skicka till ortopeden en remiss titta på de de e ju VÄRT va // ja lovar dej garanti sätt foten utanför sverige ingen vill alls titta på de här // jo om du [3 kommer]3 till ett amerikanskt sjukhus eller ett sånt	if these bullets those fragments have moved / / have they got stuck in some muscle have they come close to the joint[2 there]2 are lots of things you should think and you do not think about things like that / / y yes unfortunately I do not have time to like discuss this huh BUT let's / / send to the orthopaedist a referral look at it it is WORTH while isn't it / / I promise you I guarantee put your foot outside Sweden no one wants to look at it at all / / yes if you [3 come]3 to a U.S. hospital or a place like
P2: [2 ja]2	P2: [2 yeah]2
P3: [3 jo]3	P3: [3 yeah]3

The patient seems to listen to the physician, but when the physician leaves the room, he explodes, talking to a nurse (N):

Excerpt 9

Original (Swedish)	**English Translation**
P1: bluff å båg va // då hinner man väl dö här e // blyförgiftning // va sparar sjukhuset pengar // (...) / skrämmande // ortopeda mej hit å ortopeda mej dit // bara röntgen (...) // men skulle ja dö utav blyförgiftning i såna fall inspelat på band att ja{g} har krävt å1 bli opererad så att (...) // va fan ska	P1: Scam and trickery // you can die here of / / lead poisoning / / the hospital saves money / / (...) / scary / / orthopede me here and orthopede me there / / only x-ray (...) / / but should I die of lead poisoning in that case it is recorded on the tape that I have required to be operated so that

ja här å göra ///	(...) / / what the devil am I doing here / / /
N1: hur går de per-oskar	N1: How is it going Per-Oskar
P2: jodå // ja står å biktar mej bara	P2: Well // I am confessing only

The patient's comments "scam and trickery" and "the hospital saves money" (P1) indicate that he is suspicious about the arguments of the physician and probably does not trust him. The accounts given by the physician have thus not had the effect of raising trust; rather, the distrust of the patient has remained and possibly been strengthened.

This situation illustrates the patient's and the physician's mutual lack of both collaborative and cooperative trust. To start with collaborative trust, the physician and the patient do not work towards a joint purpose. The patient wants surgery immediately, while the physician will not offer it, defending his decision by referring to hospital procedures and stating that he does not consider the patient's problems to require immediate action. The patient may feel that the physician does not care about his opinions and problems, while the physician may experience that the patient does not believe him and his suggestions (lack of cooperative trust). Further, the patient may think that the physician did not provide him with information about potential lead poisoning on purpose, to avoid surgery and to save money for the hospital, which may also show a lack of trust with respect to commitments and obligations.

The situation further illustrates the patient's lack of trust in the physician's competence. The physician refers to his professional authority and experience without any apparent

effect, probably due to cultural differences. In Iran, physicians are often viewed as absolute authorities, and their words are rarely questioned (Behjati-Sabet & Chambers, 2005; Berbyuk Lindström, 2008), while in Sweden, patients expect explanations based on facts. In addition, similar to the case with the Iranian female physician, some lack of trust may be due to the physician being educated outside the EU/EEA. In addition, there are concerns about basic trust. When the physician terminates the interaction, it may indicate that he does not believe that the upset and stressed patient can listen to and perceive what he is talking about. Whatever the physician now tries to communicate, his accounts (justifications of actions taken/not taken) will not be found to be acceptable by the patient.

We conclude that this illustration is a clear case of a process of distrust. The patient is implicitly and explicitly questioning the collaboration and cooperation of the physician, and he is evaluating his trust with respect to the physician's commitments, obligations and competence. From the physician's point of view, it is not as evident that he is distrusting, although there are indications at the end.

The role of the accounts is important in this situation, as in the previous illustration with the cancer patient. The patient is afraid of developing lead poisoning and suspicious about the effectiveness of the health care system, possibly due to earlier experiences. To provide accounts that can lead to the suspension of doubts following such a start may be extremely difficult, not to say impossible. It may be necessary to meet again several times to earn an increasing amount of trust to repair the damage.

Discussion and conclusions

In this chapter, we have presented examples of health care dialogues to illustrate processes in which trust relations are challenged. We have also shown how accounts are provided in these situations to attempt to maintain trust. We have analysed the situations with regard to whether the accounts led to increased or decreased trust or had no apparent effect.

In summary, we have found although *basic trust* can often be assumed to be the default, in medical encounters, basic trust is perhaps challenged by the lacking linguistic competence of one of the physicians and may in this case be added to other reasons for doubts that the patient may have. In addition, the patients' difficulties in perceiving information may challenge the physicians' trust in the basic capabilities of the patients.

Collaborative trust (i.e. a belief that interlocutors will adopt and collaborate toward a joint purpose), by and large, seems to be present. In our medical encounters, parties share the purpose of communicating and carrying out the consultancy. However, there is disagreement about particular tasks (surgery to remove a bullet) when the physician does not comply with the patient's demands and the patient does not comply with the physician's advice. We can say that there is a kind of partial collaborative distrust, which is seen in the demands for accounts and the attempts to provide responsive accounts.

When it comes to *cooperative trust* (i.e. the belief that interlocutors take one into ethical consideration), the issues are more complex. There is some evidence of distrust. The

patient with a bullet in his shoulder and his physician both show evidence of being threatened with regard to their freedom of action. Since losing freedom and being uncertain about the correctness of information are unpleasant, the ethical dimension of pain and pleasure becomes involved as well.

Cooperative/collaborative trust is also linked to trustworthiness, reliability and dependability with regard to *commitments and obligations* in general, but here it is specifically related to the activities that the parties are pursuing together. There is disagreement about the arguments for not providing surgery and about the obligations of the physician and the hospital.

Finally, *trust with respect to competence* is very much at stake in situations during which the patient has a different opinion about the medical treatment from the physician. Our data show that cultural differences may explain the extent to which patients have default trust in their health professionals.

In general, we can see that trusting and distrusting are complex phenomena. In our analysis, we found that accountability and account giving come to have a crucial role in the process of increasing or decreasing trust, since this is one of the main ways in which we can obtain information concerning the five types of behavioural features that we suggested are essential for trust. We have shown that accounts can lead to trusting (Illustration I). A necessary condition is that they correspond to the uncertainty that the other party expresses, assuming willingness to collaborate and cooperate. Having analysed authentic interactions, we can claim that it is more complicated to identify

trusting than distrusting. Part of the explanation is that, although it may be possible to identify suspension of doubt, it is quite complicated to observe the leap of faith (cf. Möllering, 2006). In our illustrations, it was possible to some extent to identify suspension of doubt, but not the leap of faith. Further, accounts should be presented in an understandable way assuming both basic and area-specific competence (Illustration I). Cultural difference (Illustrations I and II) is an aspect of significance here. Finally, accounts should confirm commitments and obligations. We have shown that accounts can lead to distrusting if they do not meet these conditions.

We have found that it is complicated to counteract distrusting using accounts. This is especially true when it becomes unexpectedly necessary in an ongoing interaction (Illustration II). It requires both an awareness of the role of trust and knowledge about how trust problems are communicated, that is, realizing that the other party is uncertain about, or doubting, something that one has said or done (or not said or not done). In addition, it requires communicative skills and knowledge about how to express oneself in a careful and nuanced way. This is of course difficult when exposed to open distrust from another person face to face.

Perhaps actions taken (not taken) may be more important for trusting (distrusting) than accounts (Illustration II). The role of accounts in situations of distrusting actions is most likely to differ from the role of accounts in situations of distrusting talk. This, together with the challenges involved in analysing the leap of faith in dialogue, calls for further research, taking multimodal means of communication into consideration.

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