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**Three-party Medical Consultations in Saudi Arabia: A  
Mixed-Methods Study**

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**Thesis submitted for the degree of Doctor of Philosophy  
Linguistics and English Language  
The University of Edinburgh**

**2016**

## Abstract

One of the cultural traditions in Saudi Arabia is that the Saudi female patient has to be accompanied by a third-party on her medical visits, thus giving rise to consultations between three parties. By third-party, I mean a chaperone or a family member who can be a patient's spouse, parent, adult child, sibling, or relative. This person shares responsibility for the patient's health and the patient relies on them to support them generally with assistance in terms of their health care needs and especially for medical visits. In this research, I focus on the presence of a third party in medical consultations with reference to patient satisfaction, how patients perceive the role of their chaperones during the medical visit and the nature of three-party medical interactions. To investigate these aspects, a convergent parallel mixed method design was used in order to develop a better understanding of doctor-patient-three party interactions, as no mixed method study has been conducted on these issues in medical consultations in Saudi Arabia. Hence, this study addresses this gap in literature by focusing on the interaction between the Saudi female patients, their male physicians and their chaperones. I have concentrated on the Saudi female patients (from different age groups, i.e. 19-75) for religious and cultural reasons. Therefore, the overall aim of this thesis is to understand the phenomenon of three-party consultations in Saudi Arabia through a variety of aspects including patient satisfaction, patients' perceptions, and what actually happens in three-party medical interactions (e.g., alignment and epistemic asymmetry). The data for this study included quantitative (i.e. questionnaires) and qualitative (i.e. four open-ended questions and observational and audio-recorded) data collected in one phase from 20 clinics in 3 hospitals in Jeddah in Saudi Arabia (two private and one governmental). A total of 117 female patients along with their chaperones were recruited.

Statistical analysis of the questionnaire ratings showed that only patient's education has a positive effect on patient satisfaction with chaperone involvement. Findings from thematic analysis of the open-ended questions data revealed that patients described three supportive roles of the chaperones, namely emotional, informational and logistical support. The patients' perceptions regarding their chaperones' supportive roles are re-evaluated in a real-life context by observing the chaperone's facilitative role in three-party consultations. Therefore, conversation analysis of the audio-recorded data showed three main patterns of alignment: (1) doctor-patient, (2) chaperone-patient (and patient-chaperone), and (3) chaperone-doctor (and chaperone-patient) alignments. All these actions indicate that the participants were collaboratively involved in the positive interaction and this enhanced patient participation. However, in analysing three exceptional cases from the Chemotherapy and Haematology clinics, it was found that the presence of a chaperone dominates as well as complicates doctor-patient interaction and thus can significantly override or ostracise the patient who does not know her illness. For example, by using the Conversation Analysis approach, various epistemic resources used by the interlocutors (i.e. the oncologist and chaperones) are displayed by which the patient's epistemic primacy is usurped and her epistemic access is controlled in terms of participation and the amount of information given.

In comparing the mixed methods used in this study, congruent and discrepant results are found between the quantitative and qualitative data. In terms of congruent

results, overall, the findings of this study concurred on the importance of having a supportive chaperone during a female patient's medical appointment. Chaperones' supportive roles appear to differently influence female patients' symptoms, diagnosis or treatment plan. Chaperones in the current study have provided a useful contribution to the doctor-patient interactions. However, in terms of discrepancy, findings yielded by the conversation analysis (in Chapters 6 and 7) showed a discrepancy between what patients reported (see Chapter 5) about their chaperones' supportive roles and what their chaperones did in the consultation. For example, the thematic analysis of the open-ended questions found that both genders were equally likely to be active in speaking for the patient. However, the conversation analysis of observational data adds and clarifies to what patients reported about their chaperones speaking on their behalf. The conversation analysis has given a good picture of the chaperone's supportive role during medical visits in orienting towards patients as being the actual owners of their bodies and illness (see Chapter 6). Therefore, patients were given the chance to present their problem. Chaperones, in working collaboratively with patients and physicians, support the patient and facilitate the physician's understanding. However, in only two exceptional cases (see Chapter 7) of actual medical interactions, the chaperone acts as a surrogate patient and restricts the patient's own knowledge of their illness. Therefore, the current study contributes to three important areas, namely: (1) the literature of three-party interactions, (2) three-party interactions in Saudi Arabia, and (3) clinical practices in Saudi Arabia.

## Acknowledgements

Ever since I was a little child, I had a dream of becoming a physician and dedicating my knowledge to the community. Unfortunately because of no medical school in my town, I chose to join the Department of English Language at the Girls' College of Education in Abha. After receiving a bachelor's and master's degree in English Language with distinctions, the dream of practising medicine was still in my mind. When I joined Edinburgh University as a Ph.D. student and read some Conversation Analysis research about medical interaction, I was ecstatic; I had found myself in a field I loved or at least fulfilled a small part of my ambition. When I started this research, obstacles were coming at me one after the other. However, having marvellous people around me, I was able to finish the journey to my Ph.D. with both its bitter and sweet experiences. It was a journey full of achievement and prosperity. Here, I would like to express my deepest appreciation and gratitude to those amazing people who have generously given their time and expertise to support this research and have made this Ph.D. thesis possible. I dedicate a special thank you to those who wiped my tears, bolstered my spirit, and encouraged me in spite of the challenges I was facing as a single mother of four children, full-time student and a disabled student with a chronic illness. There are a few people who deserve a big thank you from the bottom of my heart.

To my mum and dad. It is both of you who have ignited my love for learning. You are my wonderful examples and have taught me to work hard for the things I aspire to achieve. Thank you for all the sacrifices you have made for me so I could attain a higher education. Thank you for your prayers, support, guidance, and unconditional love. Dad, I learned from you to do my best and honest work and that good reputation is worth more than a quick profit. Sorry dad I could not fulfil my and your dream to be a physician, like my brother and sister, but working in medical discourse is an acceptable substitute. Dad, I will never forget the tears of joy which fill your eyes when you see one of us climb the ladder of success. I will never forget your concern in providing all aspects of comfort and effort during my years of studying since I was a child till what I have become now. Here I promise to substitute your suffering and your hard efforts for joy, happiness and to allow you to

hold your head high. Mum, you are always my powerful influence in achieving my goals and showing me where there is a will there is a way. I learned from you never to give up despite the struggle. I raise my hat in respect of your powerful personality. Being a mum on your own (due to my father's travels), caring for a big family who have now become physicians, doctors and engineers is highly appreciated. I hope I can do the same with my children. The voice mail prayers you sent every morning through *WhatsApp* before I went to university and your energetic words through *Tango* video calls every night still ring in my ears and gave me the strength to turn my dream into a reality. To both of you, you are amazing parents who have been around me my whole life. I am extremely fortunate and proud of you. I love you more than I can say and I dedicate my heart and life to you.

To my supervisors Prof. John Joseph and Dr. Sue Widdicombe. Thank you for your support, patience and understanding of my health problem at times when my hand did not help me at all in typing this research. Dr. John, thanks for your continuous advice, guidance, your helpful comments and invaluable feedback. Dr. Sue, you have been a wonderful source of encouragement, support and guidance throughout. You have opened my mind to the utility of mixed methods research within the field of medical research. Thanks for your comments on the many drafts of my thesis and for contributing ideas for improvements, for giving me access to other academic works, and for offering a time to meet you weekly. I have had the privilege of benefitting from both of you. From the bottom of my heart, thank you.

To Tanya Stivers, your article *Negotiating who presents the problem* sparked my interest in three-party medical interactions. I am deeply indebted to you for your quick email responses and advice whenever I needed you.

To my four children, Mohammad, Leen, Ibrahim and Mamdouh. You have been a source of great learning and healing. Thank you for the great joy and happiness you bring to my life every day, for waiting for me during this long journey with patience, and even for your complaints which helped me to overcome many challenges. I have a great love for you all.

To my sisters and brothers, thank you for instilling confidence, and advice throughout my studies in the UK and for keeping me focused with your prayers and sweet words. Thanks go to my sister, Dr. Afnan, and brother, Dr. Fahad. My warm

appreciation to both of you, for spending time on the phone translating the medical terms and for responding quickly through *WhatsApp* whenever I needed your help with medical consultations.

To my colleagues and friends, especially Dr. Mona Hammouda and Dr. Amira Al-Shehri. Thank you, Dr. Mona for your weekly international call, for your sense of humour, and for being my champion and counsellor. Thank you Dr. Amira for your unforgettable help before I came to the UK, for the sense of humour we shared together over the period of my Ph.D. studies, and for formatting the whole thesis.

To the Saudi female patients and their chaperones. You are the main actors in this study; you make me feel privileged to be entrusted with observing and audio-recording the consultations as well as with your views and experiences. Your sweet words and encouragement for being a Saudi female researcher carrying out this research will not be forgotten. Thank you to every consultant, physician, and nurse and for the time you generously gave to this thesis. Thank you too for allowing me access to conduct this research. Without your help and support, this thesis would not have been possible.

To the Saudi nurses in the governmental hospital, I am indebted to your invaluable help, and for your highly supportive attitude in collecting a well-organised and thorough data. Without your support and assistance, this research would not have existed.

To King Abdulaziz University in Jeddah. A warm thank you for your financial support for my Ph.D. studies and living expenses in the UK.

To members of the Scottish Ethnomethodology, Discourse, Interaction & Talk group of the University of Edinburgh. Many thanks for your invaluable feedback on some of the audio-recorded medical transcripts of my data during the data analysis sessions.

To the Disability Office at the University of Edinburgh, a massive thank you to every member of you for the continuous support materials I needed during my Ph.D. studies and for your concern through follow up emails.

To thesis examiners, Dr. Mei-hui Tsai and Dr. Lauren Hall-lew, thank you for your invaluable feedback. Last but not least, to Jehane from *WORDSRU*. Thank you so much Jehane for editing the whole thesis and providing feedback on my writing.

## **Dedication**

This Ph.D. thesis is dedicated to

### **My beloved father**

*Abdulghafar Al-Ayyash*

For everything he has done for me to achieve higher education.

For his sacrifice, love, kindness, and patience

For placing his dreams in me,

which I hope came true

### **To my precious mother**

*Azizah Al-Shehri*

Whose words of encouragement and push for tenacity ring in my ears:

“I want you to hold your father’s head and mine high,

I want to be proud of you in front of all the people”

For everything she has done through her life

### **To my beautiful four children**

*Mohammad, Leen, Ibrahim & Mamdouh*

For their encouragement, making me laugh, for providing great joy to my life

For understanding and their enduring tolerance

of my academic studies over the years



## **Signed Declaration**

I hereby declare that this thesis has been composed by me and that the work is my own. This work has not been submitted for any other degree or professional qualification.

Signed

Maha Abdulghafar Al-Ayyash  
January 2016

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# CHAPTER 1

## Introduction

### 1.1. Background of the Study

This thesis deals with issues arising from the cultural tradition in Saudi Arabia, where the Saudi female patient has to be accompanied by a third-party on her medical visits, thus giving rise to three-party consultations. This situation raises a number of issues, including: Does the third-party's presence in medical interaction affect the patient's satisfaction? How does a female patient feel about having a third-party in a medical consultation? What actually happens in three-party medical interactions? Is the female patient given a chance to present her problem and report her history-taking to her physician? Does the third-party orient towards the patient as the actual owner of her body and illness? Or does the third-party dominate the patient in terms of the participation and the amount of information given? Plus, does the patient lack knowledge about her illness? To answer these questions, a convergent parallel mixed method design was used to develop a complete understanding of doctor-patient-third-party interactions in Saudi Arabia. Therefore, the overall aim of this thesis is to understand the phenomenon of three-party consultations in Saudi Arabia through different views including patient satisfaction, patients' perceptions, and what actually happens in three-party medical interactions, such as alignment and knowledge asymmetry. It is hoped that the results of this project will contribute to the understanding of the patients' needs concerning the supportive roles they need from their chaperones as well as develop the policy actions regarding patient autonomy in order to improve the quality of care, as well as increase the level of patient satisfaction of three-party interactions in Saudi Arabia.

This chapter begins with a discussion on the motivation for this research which is explained in 1.2. Then, the concept of the third-party in medical consultations is discussed in 1.3. In section 1.4., an overall picture of the sociolinguistic context of the Saudi society and its cultural norms are provided to enable a better understanding of the concept of the third-party, describing the Saudi society and its main issue of sex segregation with reference to the healthcare setting. The chapter ends by providing an

overview of the chapters in this thesis.

## **1.2. Personal Interest in the Research**

My interest in the phenomenon of the third-party in Saudi Arabia was inspired by Tanya Stivers's (2001) article, "negotiating who presents the problem", which was the starting point for this research. The idea of the 'third-party' started to crystallise in my mind and raised some questions that needed to be answered. Therefore, I contacted Tanya Stivers regarding my interest in three-party research in the paediatric context, who advised me to look either at paediatric interactions or exclusively at adults (geriatrics or disabled) who are accompanied and to look at how the patient is treated by both chaperone genders. After intensive reading, I finally decided to focus on adult interactions (i.e. male doctor-female patient-chaperone) where the patient is a Saudi female patient. I chose to concentrate on the Saudi female patient rather than the male patient for two reasons: (1) according to the Saudi cultural and religious norms, a female patient needs to be accompanied by a third-party when seeking treatment from a male physician (as will be shown from the Saudi context); and (2) Saudi female patients are seen as vulnerable and powerless, incapable of understanding the physician if they act for themselves, and who should not be left alone to face the stress of making a decision or the stress of knowing the bad news (Aljubran, 2010). What also strengthened the initiation of this topic was the personal contact I had with some physicians within my family and a real observation of three-party interaction in Saudi Arabia during my preliminary research in 2010. More importantly, the issues pertaining to third-party interaction had not previously been explored in Saudi Arabia. The definition of a third-party in a medical consultation is provided in the next section.

## **1.3. Who is a Third-party in Medical Consultations?**

Medical visits often involve a third person or a chaperone who accompanies the patient to the medical appointment. This person is defined in this study as a family member (i.e., a patient's spouse, parent, adult child, sibling, or relative) who shares responsibility for the patient's health and on whom the patient relies for assistance and support generally in terms of their health and especially for medical visits. Such a person has been viewed as a "secondary patient" in family medicine literature (Orzano,

et al., 2001, p. 113; Schilling, et al., 2002, p. 685). The third-party's presence has been widely discussed in almost all healthcare clinics, including paediatrics (Binder, 2010; Buchbinder, 2009; Cahill & Papageorgiou, 2007; Stivers, 2001), in work with geriatric patients (Adelman, Greene, & Charon, 1987; Beisecker, 1989; Brown, et al., 1998; Wolff & Roter, 2008, 2011), and in chronic-illness clinics, especially in work with patients with dementia (Arlt, et al., 2008), cancer patients (Beisecker & Moore, 1994; Ellingson, 2002; Jansen, et al., 2010; Labrecque, et al., 1991), or mentally ill individuals (Mphelane, 2006). In gynaecology and obstetrics clinics, a family member often accompanies a woman during her pregnancy (Chang, et al., 2006), labour (Bakhata & Lee, 2010), and delivery (Bruggemann, et al., 2007; Oboro, et al., 2011). In the intensive care, a family member is there, facing the stressful situation, as his/her loved one undergoes cardiopulmonary resuscitation (Oman, et al., 2010).

Findings from three-party interactions, reviewed by Laidsaar-Powell, et al. (2013), reveal that patients were more likely to be accompanied by a third person if they were older, female, less educated, and had poor health literacy. Previous research has examined the positive (Schilling, et al., 2002) and negative (Adelman, et al., 1987; Greene, et al., 1994) effects of the chaperone's presence on doctor-patient interaction. For example, Clayman, et al., (2005) stated that chaperones facilitate patient understanding by repeating doctor's explanations and asking questions for clarification. Chaperones also facilitate doctor's understanding by clarifying patients' illness history and introducing medical topics. However, when patients are accompanied by chaperones, the duration of the clinic tends to be longer (Labrecque, et al., 1991), patients typically raise fewer topics in all content areas (medical, personal habits, psychological factors, and physician-patient relationship), take a less active part in joint decision-making, and avoid personal conversation with the practitioner (Greene, et al., 1994). In addition, patients are usually less assertive, less responsive to the topics they do raise, and less expressive (Greene, et al., 1994). In spite of the positive and negative consequences of the third-party in a medical consultation, the presence of the third-party in other cultures, particularly in Saudi Arabia, is essential when a female patient is seeking treatment from a male doctor for religious as well as cultural reasons. In the following section, the sociolinguistic background of the Saudi society and its culture is provided followed by a spotlight on the sex segregation code

as the most salient feature that shapes the identity of this society.

## 1.4. Sociolinguistic Background of the Study

### 1.4.1. Saudi society and culture: sex segregation

The Kingdom of Saudi Arabia is an Islamic country located in the Arabian Peninsula (see figure 1) in the western region of Asia, with a land area of 2,250,000 square kilometres. It is considered to be the largest country in the Middle East, consisting mostly of desert with a mountainous region and an extensive coastline (Mufti, 2000; Walston, et al. 2008; WHO, 2006). Saudi Arabia has a native population of approximately 22.6 million, and an additional 6 million expatriates. The country's official language is Arabic, and Islam is the official religion. Saudi Arabia has one of the largest oil reserves of petroleum in the world and is its largest exporter. Exploitation of such a tremendous amount of oil wealth has led to a massive improvement in all spheres of life, especially in social and healthcare services (Mansour & Al-Osimy, 1996). In spite of such modernisation in all lifestyles, Saudi Arabia is still characterised as the most conservative as well as the most sex-segregated Islamic society.

**Figure 1.** Map of Saudi Arabia, *Source: Wikimedia Common by Einstein (2007)*



Sex segregation is the most important feature that distinguishes the Saudi society from other societies (Buchele, 2008; Gallagher & Searle, 1983, 1985). The norm of gender segregation originates ultimately from Islamic religion, which prohibits women

to mix with unrelated men to do something wrong<sup>1</sup> (AlMunajjed, 1997; Ember & Ember, 1988), and stems from the cultural tradition of gender, space, kin, and honour (Deaver, 1980). The reason behind segregation is to protect women's celibacy and honour from outsiders (AlMunajjed, 1997; Deaver 1980).

Sex segregation in this theory defines the distinct roles of men and women in Saudi society. Women are responsible for the housework (i.e. inside the house) the managing of the house and taking care of the children and ill relatives, whereas men focus on outside the household by taking care of the business and the family's financial situation and needs (Al-Khateeb, 1998; Katooa, 2014). The family unit is the basic foundation of Saudi society which has strong family relationships (Younge, et al., 1997). For example, when a member of a Saudi family is sick, the whole family gets involved not only by accompanying the patient to his/her medical appointment but also by providing the medical care and the support he/she needs. Family members or chaperones find themselves obliged by their cultural and religious norms to extend their support to their sick relatives (Aljubran, 2010).

When talking about gender segregation in Saudi society, two important issues should be taken into consideration: *male guardianship* and *honour and shame*. The notion of sex segregation is closely related to the issue of a legal guardian or *mahram*. According to the Saudi society rule, the organisation of the family is patriarchal and hierarchical by gender and age (Bahry, 1982; Sullivan, 1993; Yamani, 1996). Fathers or husbands have the power of attorney or legal guardianship (*wali-al-amr/ mahram*) over the family until death, and then authority is transferred to another eldest male legal guardian, who is a grandfather, father, brother, uncle, or nephew. Such men from the immediate female family are considered *maharem*<sup>2</sup>, (i.e. "male related to the female, by a certain degree of sanguinity," or the unmarriageable kin) (Fatani, 2008). According to a female's *mahram*, the Saudi woman must obtain the consent from her male legal guardian before leaving the house, whether the purpose is to possess a personal identity card, go to work, travel, marry, divorce, or access medical care (Buchele, 2008; Gray, 1983; Renard, 2008).

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<sup>1</sup> The religious concept is **khalwa**, which means being secluded with a person of the opposite sex who is non-mahram to commit or to do something wrong.

<sup>2</sup> Maharem is the plural form of mahram.

What strengthens sex segregation is the cultural norm of *male honour and female shame* (Deaver, 1980: 32); any violation of these dichotomies creates shame. Stiehm (1976) clearly defines the meaning of honour from the Islamic and the cultural perspectives, which means exactly the same in the Saudi society:

Honor is a crucial ingredient of every society. In Islamic cultures (and in many pre-Islamic Mediterranean cultures) male honor is closely linked to female purity: this requires virginity for the unmarried, fidelity for the married, and continence for the divorced or widowed. This conception of honor means that the behavior of an individual woman affects not only her own reputation but also that of her husband, her father, her brother, indeed that of all her male kin (p. 277).

Sex segregation rigidly applies to all public facets of Saudi social life: in hospitals, education, banking, airports, shopping centres, restaurants, businesses, wedding parties, and even in homes, where there are two separate entrances: one for men and the other for women. In most Saudi institutions, segregation by gender is clearly marked by signs and codes, such as “ONLY FOR WOMEN,” “UNACCOMPANIED WOMEN ARE NOT ALLOWED,” “FOR MEN ONLY,” or “FOR FAMILY ONLY”<sup>3</sup> (Renard, 2008: 615). Absence of the sex segregation principle in some Saudi public spheres, such as in medical colleges, hospitals, supermarkets, and airports may, on the one hand, create a kind of annoyance or irritation among some Saudi females and their legal guardians (Gallagher & Searle, 1985); and on the other hand, this can motivate the unexpected appearance of the Saudi religious police, the Committee for the Promotion of Virtue and the Repression of Vice, (translated literally in Arabic, Hay’at al-amar bil-ma’ruf wa al-nahi ‘an al-munkar) to keep any breaches under control.

The religious police’s main responsibility is to observe sex segregation, the ethical behaviour of gender, dress code, and male prayers in the mosque (Buchele, 2008; Renard, 2008). The penalty of Khalwa varies according to the situation in which the two people are arrested. It may take two forms: either jail (Verma, 2008) or lashing (Shabrawi, 2011). This punishment does not only apply to Saudi females but also to all foreign expatriates living in Saudi Arabia (Verma, 2008). It is important to note

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<sup>3</sup> My emphasis

here that not every social interaction between a man and a woman calls for suspicion or charge (Al-Ghamdi, 2010). One of these exceptions to the interactions is that between a male doctor and a female patient with the presence of a third-party in the consultation room. However, this might lead to suspicion if there is no nurse or chaperone present. The next section thoroughly discusses how healthcare institutions, with their public and private sectors, rigidly apply the sex segregation code.

#### **1.4.2. Sex segregation and healthcare**

##### **1.4.2.1. The healthcare service in Saudi Arabia**

Healthcare services are provided free of charge to all Saudi citizens and public-sector expatriates through the Ministry of Health, who acts with the cooperation of other governmental health sectors (Al-Yousuf, et al. 2002). Three main sectors are charged with providing health services for the whole population in Saudi Arabia: the Ministry of Health (MOH), other governmental agencies, and the private sector.

The MOH, as the National Health Service (NHS), is publicly funded by government budgets and mainly provides primary healthcare through a network of 1,850 primary healthcare (PHC) units across the country. These serve both urban and rural areas and integrate a referral system for secondary and tertiary-level care for general and specialist hospitals (Al-Yousuf, et al., 2002; Mufti, 2002; WHO, 2006). While the MOH is the largest provider of healthcare, providing over 60% of inpatient care, (Berhie, 1991; WHO, 2006), other governmental and private agencies also play an important role in providing healthcare for the remaining 40% (Abu-Zinadah, 2006).

Other autonomous government health provider agencies funded outside of the MOH's budget provide highly specialised facilities to their own employees and dependents. Each of these government ministries has its own budget, recruits its own personnel, and is responsible for running its healthcare system. The major government sectors include the Ministry of Defence and Aviation (MODA), which is the second largest healthcare provider after the MOH; the Ministry of Interior (MOI); and the Saudi Arabian National Guard Medical Health Affairs (SANG), all of which finance and provide all levels of care (primary, secondary and tertiary) to their employee's relatives and other selected patients (Aldossary, et al., 2008; Kluck, 1985; Mufti, 2002).

The private sector plays a complementary role in providing health facilities between the MOH and other NHS governmental providers. It has been growing rapidly over the past few years in large cities, especially after the advent of interest-free loans from the government to encourage the participation of the private sector in all aspects of the economy, particularly in setting up health facilities (Mufti, 2002; Walston, et. al., 2008). The private sector provides all health services (primary, secondary, and tertiary) and some of the large private hospitals have been competing with the public specialised hospitals to provide highly specialised care for their patients. The private sector is still considered the primary health provider for private-sector expatriates; they are not allowed to use the MOH services except for emergency purposes.

What public and private sectors have in common is applying the code of sex segregation as explained in the section below.

#### **1.4.2.2. Healthcare institutions and sex segregation**

Sexual segregation, with its public and private domains, is also found in healthcare settings. For example, with the ongoing construction of hospitals and health centres in Saudi Arabia, the architectural design requires separate areas for females and males within a common building, using screens or partitions rather than having a whole building for each sex (Gallagher & Searle, 1983). Although there are separate-sex waiting rooms and wards, there are common entrances and shared elevators used by both sexes. The use of the latter is particularly disturbing to some females as it gives them a feeling of discomfort, as if they are being imprisoned with males (Ibid).

On the basis of the spatial segregation norm, the presence of Saudi women in an open public space requires female modesty (Gallagher & Searle, 1983). In the public domain, almost all Saudi women always wear extremely modest clothing, particularly the veil (*hijab*), which fully conceals their heads and faces. Their bodies and clothes are completely covered by a long black cloak called the *abaya*.

For a Saudi female patient attending a medical appointment, being alone with an unrelated man in the same room is considered a religious as well as a cultural taboo (Gallagher & Searle, 1983). The MOH applies the Islamic rule of having a male family member/mahram accompany the female patient when visiting a male physician. Consequently, the MOH has released a law banning male physicians from being alone



with female patients. This applies to all governmental health providers and private hospitals throughout Saudi Arabia (Bashraheel, 2010; personal telephone communication). Such a directive aims to protect male doctors and medical staff from false accusations of misconduct while also protecting the female patient from abuse (Al-Gaai & Hammami, 2009; Bashraheel, 2010).

However, from a healthcare perspective, such a law affects women's health in various ways (Mobaraki & Söderfeldt 2010). In some cases, the presence of the male chaperone with the female patient may expose her life to danger if he does not accept the male physician's treatment. For example, in some rural areas, some legal male guardians may be reluctant to allow their female relatives to be treated by male obstetricians or gynaecologists, even in emergency cases (Abu-Aisha, 1985). In Abu-Aisha's (1985) study, the female patients were never asked their opinion, even though they were mentally competent. Likewise, the presence either of a male family member or a female nurse is a necessity during a female patient's physical examination; otherwise, intimate disclosure is impossible. However, as long as the female patient's face is fully covered there is no problem in undressing for a physical examination because it is as if she is invisible (Al-Kassimi, 2003; Dubovsky, 1983; Gray, 1983; Rhine, 2000).

Therefore, understanding the nature of the third-party's presence with the positive and negative consequences in medical consultations necessitates the current study. To date, the presence of the third-party remains unclear, particularly in Saudi Arabia. Thus, the overall aim of this study was to understand the phenomenon of three-party consultations in Saudi Arabia. To achieve this aim a number of questions needed to be answered. These include: (1) what are the factors that influence patient satisfaction in three-party interaction? (2) what are the perceptions of the female patients regarding their chaperones' roles during their medical visits? (3) how does alignment occur in three-party interactions? and (4) how is epistemic asymmetry managed in triadic interactions?

To answer the above mentioned different research questions, a convergent mixed methods design was used to present "a greater diversity of divergent views" (Tashakkori & Teddlie, 2003, p. 676). Therefore, a convenient sampling approach was adopted. The sample collected for this study consisted of all individuals who

attended the twenty outpatient clinics in Jeddah from November, 2011 to January, 2012. A total of 117 female patients along with their chaperones were recruited. The databases for this study included quantitative and qualitative data collected in one phase (or concurrently) from twenty clinics in three hospitals in Jeddah in Saudi Arabia (two private and one governmental). In terms of quantitative data, I gathered questionnaires (i.e. patient's self-ratings about the medical visit where the third-party was included). Concerning the qualitative data, I analysed the four open-ended questions about patients' experiences regarding their chaperones' presence during medical visits. In addition, I observed a real-life three-party interaction. For data analysis, I used statistical analysis for the questionnaire data, and thematic analysis as well as Conversation Analysis (hence CA) for the qualitative data (see the comprehensive methodological approach in Chapter 3).

Thus, the results from one method, combined with those yielded by the other, provide an opportunity for more elaboration, enhancement and clarification and "increase interpretability, meaningfulness and validity" of the findings (Greene, et al., 1989, p. 259), allowing the study to make a distinct contribution to the pertinent literature. Therefore, the use of mixed methods in the present study makes a meaningful contribution to the research field in several ways. First, this research will contribute to understanding the characteristics of three-party interactions in Saudi Arabia, since the review of the literature reveals that the issues pertaining to the presence of the third-party have not yet been investigated in Middle Eastern societies, particularly in Saudi Arabia. Second, the findings of this study will assist chaperones and patients alike by incorporating chaperones into patients' care, as a valuable support mechanism as well as a complementary member in the patients' consultation. In this way, the chaperones can better understand patients' needs and patients will be better equipped to cope with their illness. This, in turn, will improve their treatment and consequently increase their level of satisfaction (Dein & Stygall, 1997; Wolff & Roter, 2008). Third, the CA findings will encourage chaperones to treat the patients as individuals having an epistemic right to present their own problem when they have been selected as the next speaker. Fourth, this study adds to the literature on epistemic asymmetry in three-party medical consultations, which has not been studied in depth. The case study suggests that the CA framework for three-party medical encounters can

be used to investigate the features of epistemic dysfunction of institutional medical encounters, i.e. the patient remains blind and unaware of the stage of her disease. It is hoped that the findings of this study will change the chaperone's misconception and myths that 'disclosing cancer diagnosis equals death to the majority of patients (Al-Amoudi, 2013; Mobeireek, et al., 1996) and will develop legislation concerning patient autonomy. In the following section, an overview of the chapters provided in the thesis is presented.

## **1.5. Overview of the Thesis**

In Chapter Two, I provide a critical review of the past studies in three-party consultations regarding the issues of patient satisfaction, patient perceptions, alignment and knowledge asymmetry. As I will show, both qualitative and quantitative studies present the positive and negative attitudes of the third-party presence, with reference to patient satisfaction and patient perception, in medical consultations. However, overall, the third-party studies are restricted in terms of the range of patient samples, the methods used, the fact that most of these studies have been conducted in the USA (one of which was a mixed method study), very few studies have used Conversation Analysis to examine alignment and knowledge asymmetry in three-party medical interactions, and there is no evidence of similar research conducted in the Middle East, particularly in Saudi Arabia.

In Chapter Three, I describe the research methodology employed in designing and conducting data collection. Therefore, the chapter comprises three parts. In the first part, I discuss the mixed method research employed in this study with relation to its advantages and disadvantages. In the second part, I describe the data collection method for this study, including negotiation of healthcare access, audio-recording and observations, questionnaires, study settings and participants, ethical considerations, observer's paradox, and problems encountered in data collection. The third part closes by delineating the strategies used for ensuring trustworthiness of the qualitative research conducted in this study, based on the suggestions made by Lincoln & Guba (1985).

In Chapter Four, I present the steps in analysing the questionnaire data then I discuss the statistical findings of the research questions regarding the effect of the

patient's age, their level of education, the chaperone's gender, on patient satisfaction with (1) overall care; (2) chaperone care; and (3) chaperone involvement. The statistical analysis revealed that the patient's education has a significant effect on the patient's satisfaction with chaperone involvement. This finding will be evaluated and compared to the results of the qualitative thematic analysis in Chapter Five.

In Chapter Five, I examine how Saudi female patients perceive the positive role of their chaperones during their medical encounters and any variations in role characteristics that stem from the chaperone's gender. Therefore, this chapter has been divided into three parts. In the first part, I explain Braun & Clarke's (2006) six-step guide adopted to conduct a thematic analysis. Then I report the patients' perceptions regarding their chaperones' positive roles. The third part deals with the findings regarding gender variation in role which explores the patients' needs. The findings show three supportive roles of the chaperones, namely emotional, informational and logistical. Concerning chaperone gender, it has been shown that female chaperones are the main source of emotional support more than their male counterparts. The patients' perceptions regarding their chaperones supportive and facilitative roles will be re-evaluated in a real-life context by observing the chaperone facilitative role in three-party consultations as seen in the following chapter aiming to make a link between patient perception and understanding three-party interaction.

In Chapter Six, I examine in close detail the emergence of alignment in three-party interactions using the Conversation Analysis framework. Therefore, in the first part, I explain the steps in analysing the observation data, whereas in the second part I present the findings. The findings show three main patterns of alignment: (1) doctor-patient (patient-doctor), (2) chaperone-patient (and patient-chaperone), and (3) chaperone-doctor (and chaperone-patient) alignments. All these actions indicate that the participants were collaboratively involved in the positive interaction that enhanced patient participation. Patient participation in this study is the result of the physician's selection practices, aimed at establishing who has the primary authority to present the problem, as reported in previous studies (Stivers, 2001). To support patient participation, I show that the chaperone aligns and affiliates with the patient and doctor through various actions, i.e., confirmation, repetition, expansion, and turn completion, albeit with different motivations. These findings support the conclusions of several

previous studies (Ellingson, 2002; Hamilton, 2013). Such successful alignment reveals the “synergistic style” (Ellingson, 2002, p. 377). However, the presence of the chaperone dominates as well as complicates doctor-patient interaction and thus significantly overrides the patient who does not know anything about her illness, as will be shown in Chapter Seven.

In Chapter Seven, I adopt a case study approach to investigate the epistemic asymmetry in three-party interactions with reference to two exceptional cases from the Chemotherapy and Haematology clinics to describe patients “behind-the-scenes” (Speice et al., 2000, p. 108), i.e. a patient who does not know her illness either partially or completely. By using the Conversation Analysis approach, I show the various epistemic resources used by the interlocutors (i.e. oncologist and chaperones) by which the patient’s epistemic primacy is usurped and her epistemic access is controlled in terms of participation and the amount of information given. All these resources have clinical implications which are detailed in the following Chapter.

In Chapter Eight, I summarise the central findings that have emerged from this project with reference to the aforementioned four research areas, i.e. patient satisfaction, patient perception, alignment and knowledge asymmetry. I evaluate the quality of mixed methods used in this study and in what way the quantitative and the qualitative results converge and diverge. Thereafter, I discuss how this study can make various contributions to; (1) patient satisfaction,(2) patient perception literature in terms of gender effects and gender variations in care, especially in Saudi Arabia, (3) the limited CA literature on alignment in adult three-party interaction by understanding the chaperone’s social roles in supporting their sick relatives in Saudi Arabia, and (4) to the research of epistemic asymmetry – which is a new field in CA research, by developing a code and legislation regarding patient autonomy in Saudi Arabia. I conclude with suggesting possible topics for future research, statistical analysis, thematic analysis and conversation analysis in order to enhance patient satisfaction with their medical consultations, particularly with chaperone involvement, to change the misconception of cancer diagnosis, and to improve patient autonomy.

## CHAPTER 2

### A Literature Review on the Third-party in a Medical Encounter

#### 2.1. Introduction

I have mentioned in chapter one that a concept has emerged from the Saudi cultural tradition where a third party has to accompany a female patient when seeking medical treatment from a male physician. I have also discussed that, with the presence of a third party in a medical encounter, a number of issues have arose regarding patient satisfaction with the presence of her chaperone in the medical room, the patient's perception of her chaperone's role, and what actually happens in real three-party interactions (i.e. either positive or negative attitudes). Therefore, the aim of this chapter is to provide a critical review of previous studies in three-party consultations regarding the issues of patient satisfaction, patient perceptions, alignment and knowledge asymmetry.

The rationale behind focusing on these aspects of three-party interactions is strongly related to the following reasons: first, patients' ratings of the impact of their chaperone's involvement on their satisfaction direct healthcare providers to patients' needs. Second, as patients' ratings are not sufficient in understanding third party roles, capturing patients' experience of the care they receive from their chaperones is of great value; patients' perceptions add meaningful explanation to how patients have rated their chaperones' involvement in medical visits as well as identifying patients' needs and their perceptions of treatment quality. The purpose is to find out whether or not any conformity or discrepancy might arise between patients' ratings and what they have reported about their chaperones' attitudes during the medical appointment. Third, as patients' rating and reporting are insufficient to create a complete picture of the third party in medical encounters, real-life observation is greatly needed to check against how patients rated and reported regarding their chaperones' attitudes to find any disparity between what patients say and what they actually do. The observation of three-party interactions reveals the chaperones' attitudes: either cooperative (alignment) or dominating (knowledge asymmetry). Such observation will provide

insights into chaperones' dominating attitudes and helps to develop policy regarding patients' autonomy in medical encounters. Fourth, there is a need for more up-to-date research to uncover the phenomenon of three-party interaction from different aspects and from different cultures, particularly in Saudi Arabia. Therefore, it is important to review these issues in previous research.

In this chapter, I will first discuss the concept of three-party consultations and the effect of patient and chaperone sociodemographic factors on patient satisfaction (section 2.2), with reference to the literature. In section 2.3, I will explain the concept of patient perception and review the prior empirical research that examined patients' perceptions of their chaperones' roles and the rationale behind their chaperones' attendance during their medical appointments. In section 2.4, I will present a literature review on the concept of "alignment" in sociological studies, followed by discussing earlier medical studies that dealt with the notion of alignment in three-party medical interactions. In section 2.5, I will discuss the two meanings of epistemic asymmetry (i.e. a chaperone's dominating attitude, and non-disclosure of a patient's illness), then I will review previous medical research into how epistemic asymmetry works in three-party medical interactions and how it emerged as the Saudi socio-cultural norm of non-disclosure. The chapter concludes by summarising the main research questions that this thesis attempts to answer.

## **2.2. What is Patient Satisfaction?**

Patient satisfaction is one of the most frequently discussed topics in existing research and it is regarded as an important component and a measure of the quality of care (Donabedian, 1980; Ware, 1981). Patient satisfaction can be defined as their personal evaluation of the quality of healthcare services relative to their expectations of quality standards (Campen, et al., 1995; Ware, et al., 1983). Dissatisfaction with healthcare services occurs when the quality of care received is lower than expected (Campen, et al., 1995). Patient satisfaction survey data is useful for healthcare providers as it provides valuable information about health, medical care services, and the providers of those services (Ford, Bach, & Fottler, 1997; Ware, 1981).

Patients' subjective ratings of medical care services have a number of important uses, as suggested by Ware (1981). First, they reflect the individual

differences in patients' expectations and their preferences. Second, they are considered a measure of healthcare weakness and its recovery, which requires the identification of failure and communication with patients. Third, they are also helpful in programme evaluation and in identifying areas of potential improvement (Ware, 1981). Generally speaking, patients' views on the quality of care and patient satisfaction are commonly considered as an anticipated outcome when the care is being evaluated (Larsson & Wilde-Larsson, 2010). This is especially true in three-party consultations that may direct clinicians and healthcare providers to the patients' needs which, if fulfilled, have a positive impact on patient satisfaction (Mercer, et al., 2008).

Patient satisfaction with the overall medical visit and the care provided by the physicians was the most widely measured outcome of chaperone involvement in three-party medical consultations. In three studies conducted in different medical settings, these outcomes were assessed through the use of items adapted from various questionnaires (Rosland, et al., 2011), namely, primary care (Shields, et al., 2005), geriatrics (Greene, et al., 1994), and oncology (Labrecque, et al., 1991). In these studies conducted in the USA, the authors examined patients' perceptions (in dyadic and triadic clinics) regarding their overall satisfaction with the medical visit and the impact of their chaperones on physician-patient interaction. The findings showed no significant differences between accompanied and unaccompanied patients, as both groups expressed a similar level of satisfaction with the medical visit.

However, the findings of a few studies (Rosland, et al., 2011; Street & Gordon, 2008; Wolff & Roter, 2008) revealed a significant link between patient satisfaction and chaperones' involvement. The reason behind these differing results might be the use of inconsistent satisfaction measures (Laidsaar-Powell, et al., 2013); the two studies which focused on the effect of the chaperones' active involvement on patient satisfaction reported contradictory results for the chaperone's participation in medical consultations. For example, Street and Gordon (2008) reported that patient satisfaction was generally high and did not correlate with the degree of the chaperone's active participation, but when patients and chaperones had similar levels of active participation, patients were less satisfied with the medical visit compared to those accompanied by either passive or more active chaperones. However, the authors failed to clarify why the patients were dissatisfied with their chaperones' parallel active



involvement. Conversely, cardiovascular or diabetes patients who were part of the study conducted by Rosland, et al. (2011) were more satisfied with their physician's care when their chaperones actively participated in doctor-patient interaction.

Chaperones' involvement is not the only factor in determining patient satisfaction, but other independent factors play a role as well, as explained in the following section.

### **2.2.1. Patient satisfaction factors**

Patient satisfaction, according to Larsson and Wilde-Larsson's (2010) model, is affected by the interaction between two important conditions: personal conditions and external objective care conditions. The former includes 1) socio-demographic characteristics (i.e., sex, age, education, etc.), 2) health condition, and 3) personality. The latter comprises various aspects related to the care setting such as the hospital, personnel, etc. Therefore, the correlation between patients' socio-demographic characteristics and the perceived level of satisfaction may direct healthcare providers to the patients' needs and their perceptions of treatment quality (Ford, Bach, & Fottler, 1997; Mercer, et al., 2008).

Several studies examined the correlation between certain independent variables (e.g., chaperones' involvement, and patient's socio-demographic characteristics) and their effects on patient satisfaction. For example, Street and Gordon (2008) examined whether chaperones' involvement varies with respect to patient' demographics (age, race, education level, health status), type of visit (first, follow-up), confirmation of lung cancer diagnosis, and the proportion of physicians' facilitative talk. The researchers also investigated whether the satisfaction score differed depending on the chaperones' active or passive role. Their results revealed no significant differences among chaperones' involvement, patients' characteristics, type of visit, confirmation of lung cancer diagnosis, and the proportion of physicians' facilitative talk.

However, Rosland, et al., (2011) examined the effect of male patients' low health literacy and depressive symptoms on chaperone involvement. Their findings showed that chaperones' involvement increased with patients' decreased health literacy, as well as the extent of the patients' depressive symptoms. In another study, involving a large sample of elderly patients in the USA, Wolff and Roter (2008)

investigated the impact of patients' education, health status, and chaperone involvement on patient satisfaction. The authors reported that more patients with active chaperones were highly satisfied with their physicians' information sharing than those patients whose chaperones were less active during the medical visit. With respect to the impact of patients' education and self-rated health on patient satisfaction with the physicians' skills, the results indicated that patients who did not graduate from high school and whose health was rated "fair" to "poor" reported lower level of satisfaction. While very informative, the findings Wolff and Roter reported cannot be generalised, as their study participants were older patients, who tended to be less educated and to suffer from compromised health.

A number of critical remarks on such studies on patient satisfaction can be made here. First, most extant studies on patient satisfaction with care provided in three-party interaction have focused on either elderly patients (Greene, et al., 1994; Shields, et al., 2005; Wolff & Roter, 2008), male patients only (Rosland, et al., 2011; Street & Gordon, 2008), or geriatric female patients only (Greene, et al., 1994), and only one study examined patient satisfaction using a range of patients from different ages (Rosland, et al., 2011). Second, certain demographic variables such as patients' age and health status were examined instead of other variables, and their effect on patient satisfaction with their chaperone's active participation assessed (Rosland, et al., 2011; Street & Gordon, 2008). Third, the majority of studies that examined factors affecting patient satisfaction with three-party visits have been conducted in the USA, with no evidence of similar research conducted in Middle East, particularly in Saudi Arabia.

Thus far, no study has assessed the effect of chaperones' involvement and the factors influencing patient satisfaction in three-party consultations. Therefore, this study attempts to fill this gap by answering the following questions:

**What are the factors (e.g., patient's age, patient's education, and chaperone's gender) that affect patient satisfaction with 1) overall care, 2) chaperone care, and 3) chaperone involvement in three-party consultations?**

Patients' ratings about the effect of their chaperones' involvement on patient satisfaction are not the only theme discussed in the literature under the general umbrella of three-party consultations, but patients' perceptions of chaperones' roles were also empirically reported, as discussed in the following section.

### **2.3. Patients' Perceptions of Chaperones' Roles**

Making patient perception the main focus of the three-party medical visit is an integral aspect of patient-centred research (Michie et al., 2003). Patient-centred method is a measure widely used in primary care that assesses doctor-patient behaviours with respect to three main criteria: 1) "understanding of the patient's disease and experience", 2) "understanding the whole person", 3) "finding common ground," which refers to the therapeutic alliance and agreement on the nature of the illness, and shared decision about treatment and the roles of the clinician and the patient (Stewart et al., 1995; Mead & Bower, 2002; Roter & Hall, 2006, p. 53). Therefore, to understand the patient's needs and provide optimal patient-centred care, they should be asked to share their perceptions regarding the care they received either from their physicians or their family members. What patients think and how physicians and patients' chaperones are providing care are important topics to consider, as this determines the overall quality of healthcare delivered (Zanini et al., 2014). Capturing patients' experiences of care can help physicians and chaperones to identify patients' needs, and improve the management of physician-patient-chaperone interaction (Holzmueller, Wu, & Pronovost, 2012).

Prior research on patient perceptions of the chaperone role, reviewed by Laidsaar-Powell et al. (2013) indicated that many researchers have empirically examined patients' perceptions regarding their chaperones' roles and the rationale behind their attendance in outpatient medical clinics. Eight of these studies were quantitative (Andrades et al., 2013; Glasser et al., 2001; Ishikawa et al., 2005a, 2006; Prohaska & Glasser, 1996; Schilling et al., 2002; Street & Gordon, 2008; Wolff & Roter, 2008). Of the remaining two, one was qualitative (Speice et al., 2000) while in the other study the researchers adopted mixed methods (Beisecker et al., 1996). In assessing the role and rationale of the chaperones' attendance, the authors of the aforementioned quantitative studies used closed-ended questionnaires to quantify the

chaperone's role, whereas qualitative studies relied on structured focus group discussions, enabling the patients to describe their personal feelings and perceptions in detail using their own words. These studies were conducted in different settings including: geriatric clinics (Glasser et al., 2001; Street & Gordon, 2008; Wolff & Roter, 2008), oncology clinics (Beisecker, et al., 1996; Speice et al., 2000; Street & Gordon, 2008), and primary care clinics (Andrades et al., 2013; Schilling et al., 2002). The majority of these studies of patients' perceptions were mainly conducted in the USA (Beisecker et al., 1996; Glasser et al., 2001; Prohaska & Glasser, 1996; Schilling et al., 2002; Speice et al., 2000; Street & Gordon, 2008; Wolff & Roter, 2008), with only two that reported on research elsewhere; one in Japan (Ishikawa et al., 2005a, 2006) and one in Pakistan (Andrades, et al., 2013).

Patients in extant studies evaluated the role of their chaperones through their interactions with physicians (Beisecker et al., 1996). Findings from these studies indicate that most patients found chaperones helpful and their contribution to the visit satisfying (Prohaska & Glasser, 1996). However, in some studies patients assessed the chaperone role according to their needs (Speice et al., 2000; Wolff & Roter, 2008). The most important role or reason for chaperone attendance reported by geriatric patients and patients from different age groups in the USA was to provide logistic support (i.e., transportation and physical help), informational support (i.e., reporting patient's symptoms, increasing patient understanding, recalling information, and asking questions), and emotional support (Glasser et al., 2001; Schilling et al., 2002; Wolff & Roter, 2008). However, the same findings did not apply to cancer patients, who indicated that they mostly valued their chaperones' emotional support (providing company and comfort), followed by informational support, and lastly logistic support (Beisecker et al., 1996; Speice et al., 2000). However, in a cross-sectional quantitative study conducted on adult patients in Pakistan, Andrades et al. (2013) found that the most valued chaperone contribution to the visit stemmed from emotional support, logistic support and informational support. Although the kind of chaperones' supportive role was similar in previous research, the order of importance and frequency differs according to the type of medical visit, as well as according to the patients' illness trajectory and needs.

Based on the above findings, it is worth making some critical remarks. First, both the existing quantitative and qualitative studies on chaperone role during a medical visit failed to ascertain the rationale behind the patient's preference for a particular chaperone's role relative to others. Second, in most such studies researchers failed to provide a clear definition of each chaperone's role being offered to the patient. Third, the majority of quantitative studies regarding chaperones' roles reported frequencies of their supportive as well as dominating roles only based on patients' ratings (Laidsaar-Powell et al., 2013). Finally, thus far no studies on chaperone role have been conducted in Middle Eastern Arab countries, particularly Saudi Arabia. Moreover, Saudi medical studies have largely neglected patients' perceptions regarding the role and the communication style of their chaperone during a medical visit.

The present study is aimed at addressing this gap by building on previous research on patients' perceptions in three-party interaction to investigate patients' perceptions of their chaperones' roles during medical consultation. Therefore, current research has been designed to answer the following question:

**What are the perceptions of the Saudi female patients regarding their chaperones' roles during their medical visit and do chaperones' roles vary according to chaperone gender?**

Patients' satisfaction, as well as patients' perception regarding their chaperones' roles in medical encounters are not the only issues investigated in the literature, but how third-party interactions are practised in reality was also examined with relation to chaperones' positive roles as seen in the following section.

#### **2.4. The Conceptualisation of Alignment**

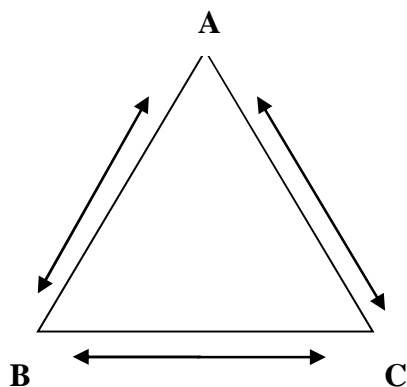
Alignment is an important factor in achieving meaningful interaction (Pickering & Garrod, 2004, 2006) and inter-subjective understanding (Heritage, 1984a). According to Nofsinger (1991), alignment refers to the utterance being "used to frame messages for purposes of clarifying, interpreting, and managing conversational meaning and communicator roles" (p. 111). Therefore, participants

achieve meaningful interactions by aligning their actions and roles in an orderly way that confirms their mutual understanding. The term “alignment” has been used in sociological and medical studies in relation to different concepts, such as alliance (Clayman, et al., 2005), agreement (Beach, 1995), concordance (Bell, et al., 2007), nextness (i.e., contiguity, progressivity) (Schegloff, 2007), and coalition (Coe & Prendergast, 1985).

In an empirical study, Coe and Prendergast (1985) defined “coalition” as the interaction between two participants of a triad “to achieve a mutually desired goal despite the active or passive resistance of the third member” (p. 241). The phenomenon of coalition formation within a triad has attracted the attention of sociologists (Caplow, 1956, 1959, 1968; Simmel, 1950; Wilmot, 1987). Following a study of triadic interaction, Simmel (1950) was the first to assert that the interactional dynamics of a two-person group changed completely when a third person is present. According to Simmel (1950), the addition of the third party has several important effects upon dyads. First, intimacy usually tends to be lost regardless of the strength of the triadic parties (e.g., doctor-patient interaction is interrupted by the presence of a third individual). Second, a coalition might form between two parties, excluding the third. As a result, the third person makes it easier for one participant to be marginalised from the discourse while the other two parties continue the interaction. Although Simmel never explained the concept of coalition explicitly, he did discuss choices of coalition partners and examined these choices in the philosophical and political contexts.

Simmel’s theme of a coalition in a triad was subsequently developed and extended within social psychology by Caplow (1959, 1968). His theory of the coalition formation depended on the initial distribution of power in a triad. Caplow (1968) stated that as every triad has three participants (denoted as A, B, and C) and the geometry of a triad has a tendency to form a primary dyad composed of a member A and member B, denoted as AB. The same principle applies to other combinations, leading to the predicted coalitions AB, BC, and AC, as seen in Figure 2.

**Figure 2.** Coalition in triad, adapted from Caplow (1959).



It is clear that Caplow's investigation of coalition resembles Goffman's (1981) notion of participant alignment that, according to Schiffrin (1993, p. 233), refers to the way participants position themselves relative to one another, e.g., their relationship of power and solidarity, their affective stances, their footing (Goffman [1979] 1981b); they are part of the broader notion of participation structure (or framework), i.e., the way that speaker and listener are related to their utterances and to one another. (Goffman, 1981, p. 3)

However, these authors (Simmel, 1950; Caplow, 1959, 1968) failed to explain how coalition is formed through interaction among three members. In what follows, the third party's role in medical consultation is discussed through previous medical studies, casting some light on the views of patients, physicians, and researchers.

#### **2.4.1. Medical studies of alignment in three-party medical interaction**

Previous medical studies have documented alignment in three-party consultations from patients' (Adelman et al., 1987; Beisecker et al., 1996; Boehmer & Clark, 2001; Clayman et al., 2005; Coe & Prendergast, 1985; Ellingson, 2002; Rosow, 1981), physicians' (Beisecker & Moore; 1994; Barone, Yoels, & Clair, 1999), or researchers' perspectives (Clayman et al., 2005; Ellingson, 2002; Greene & Adelman, 2013). Seven of these studies were qualitative (Adelman et al., 1987; Beisecker & Moore; 1994; Boehmer & Clark, 2001; Coe & Prendergast, 1985; Ellingson, 2002; Rosow, 1981), one was quantitative (Clayman et al., 2005), whereas one was a mixed method study (Beisecker et al., 1996). Most of these studies were conducted in the US

(Barone et al., 1999; Beisecker et al., 1996; Beisecker & Moore, 1994; Boehmer & Clark, 2001; Clayman et al., 2005; Coe & Prendergast, 1985; Ellingson, 2002), and focused on geriatric (Barone et al., 1999; Clayman et al., 2005; Coe & Prendergast, 1985) and oncology settings, where the patient is elderly (Beisecker & Moore, 1994; Beisecker et al., 1996; Boehmer & Clark, 2001; Ellingson, 2002; Rosow, 1981).

In the medical setting, alignment is formed between two participants without the third, based on six factors: 1) gender of the accompanying person 2) his/her relationship to the patient; 3) the type of subjects being discussed; 4) the purpose of the interaction among the three participants; 5) the time constraints of the interaction; and 6) the type of medical encounter (Greene & Adelman, 2013). In the previous literature reviewed as a part of this study, researchers outlined multiple types of alignment that develop or are exhibited during a single triadic visit, namely 1) doctor-patient alignment versus chaperone; 2) patient-chaperone alignment; 3) doctor-chaperone alignment versus patient; and 4) chaperone-chaperone alignment. These alignments may shift during any interactions, depending on the subject being negotiated (Greene & Adelman, 2013). One of the most important purposes for forming alignments is to ensure that the patients' needs are met (Ellingson, 2002).

*Doctor-patient alignment versus chaperone* is formed for different purposes (Beisecker & Moore, 1994; Boehmer & Clark, 2001; Greene & Adelman, 2013; Rosow, 1981). First, the doctor might use it to assert his/her power and authority in order to support the patient in a potential conflict with the chaperone. Second, the alignment may be motivated by the need to control a patient's chaperone and prompt him/her to follow the patient's or doctor's directions. In such alignments, the chaperone is clearly excluded from the interaction or decision-making processes.

*Patient-chaperone alignment* develops or emerges primarily when the patient and the chaperone wish to accomplish their goal of the visit (Beisecker & Moore, 1994; Boehmer & Clark, 2001; Clayman et al., 2005; Coe & Prendergast, 1985; Greene & Adelman, 2013; Rosow, 1981). They are most evident when the doctor is busy and not concerned with the patient. In addition, such alignments are motivated by the need to obtain the doctor's second opinion regarding the patient illness (Beisecker & Moore, 1994); however, in some cases the chaperone aims to persuade the patient to do something the doctor wants (Beisecker & Moore, 1994). Beisecker and Moore (1994)



found that patient-chaperone alignment is a beneficial alliance for most of the physicians. In visits signified by strong patient-chaperone alignment, Boehmer and Clark (2001) found that chaperones' participation is usually driven by patients' initiatives.

*Doctor-chaperone alignment* is characterised by the increase in a chaperone's participation, which is initiated by the physician who asks his/her opinion regarding patient's symptoms, treatment plan, or decision-making (Barone et al., 1999; Boehmer & Clark, 2001; Clayman et al., 2005; Coe & Prendergast, 1985; Greene & Adelman, 2013; Rosow, 1981). While there are many reasons for communicating with patients' chaperones instead of patients themselves, the main one is the need to obtain accurate information. This is usually the case when the physician has already discussed the patient's issues and wishes to validate the information revealed in order to make a diagnosis (Barone et al., 1999). When physicians think that they have received insufficient information, they tend to form a coalition with the chaperone aiming to elicit more data, even if the patient is capable of speaking. Therefore, the chaperone's input is solicited to "help fill in the gaps" (Barone et al., 1999, p. 681). In addition, such alignments are formed when there is a need to persuade the patient to follow a regimen or to gain the doctor's agreement for something the chaperone wants (Barone et al., 1999). In some cases, patients have difficulty in communicating with physicians because of their physical and cognitive health status (Barone et al., 1999) or frailty (Boehmer & Clark, 2001) and need assistance in conveying their thoughts and feelings. In this case, doctor-chaperone alignment is formed whereby chaperones act as negotiators or interpreters between physicians and patients. The drawback of this alignment is that the patient's presence in the consultation room is often ignored and is thus marginalised from the medical communication due to not taking part in the joint decision-making (Baker et al., 1997; Greene et al., 1994).

*Chaperone-chaperone alignment* (i.e., internal alignment) is also developed when more than one family member accompanies the patient to the medical visit. In such cases, some family members can conflict with others due to disagreements pertaining to the patient and the treatment (Beisecker & Moore, 1994). When such alignments emerge, the physician's job is to provide sufficient information to all present as a way of addressing the conflict. In summary, the alliances developed

during medical consultation are motivated by the need to put one's point across in order to obtain the best possible treatment plan and best outcome for the patient.

In interpreting the findings of the previous studies, one critical remark should be added here. The above mentioned studies on alignments in triadic medical interactions have ignored the specific variety of the different types of linguistic alignment practices that are used by the participants to align and affiliate with one another. Therefore, the current thesis attempts to fill this gap by conducting conversation analysis of third party medical interactions in Saudi Arabia, where such type of research has not been studied before.

In the next section, the association between alignments and the role played by the chaperone during medical encounter is discussed.

#### **2.4.2. Association between chaperones' roles and alignment formation**

Authors of several studies have reported a strong relationship between chaperones' roles and the structural formation of alignment in medical encounters (Beisecker et al., 1996; Greene & Adelman, 2013). The role that chaperones play in a medical encounter and alignment formation depends on the duration of the visit, content of the interaction, health and cognitive status of the patient, the extent of the chaperone's participation in the consultation, and his/her relationship to the patient (Greene & Adelman, 2013). Beisecker et al. (1996) argued that the presence of a chaperone in a medical visit changes the formation of alignment from physician-patient to that of physician-patient-chaperone. Thus, the shift of alignment has a close association with the chaperone's role.

Previous studies have revealed the presence of a close interaction between institutional roles and aligning activities in the medical room (Asmuß & Oshima, 2012). For example, in their conceptual framework for understanding the role of the third party in alignment formation in geriatric medical interaction, Adelman, Greene, and Charon (1987) categorised three major roles for the third person in a geriatric clinic. These were defined from the patient's perspective and comprised of: the advocate, the antagonist, and the passive participant. In terms of alignment, Adelman et al., (1987) argued that the proposed third person role categorisations help in

revealing potential alignments that might be established. For example, the chaperone assumes the role of an advocate when he/she is a patient activist, a patient extender, or a doctor-patient mediator. However, the antagonist role typically emerges when the chaperone needs to play two sub-roles, namely those of the saboteur or underminer. In such cases, the third party can work against the patient, with or without the physician's assistance. In contrast, no alignments exist when the chaperone is a passive participant. However, in interpreting these findings it is essential to note that Adelman et al., (1987) studied third party roles and alignment from patients' perspectives only, without taking into account physicians' perceptions or how physicians benefit from the presence of the third party. In addition, their framework has not been empirically studied in other cultural contexts, such as that of Saudi Arabia.

Likewise, in chaperone-patient alignment, previous research has shown that the chaperone takes responsibility for interpreting information to the patient; facilitating the exchange of factual information, and clarifying its meaning from the doctor, particularly in cases where the patient resists or rejects the doctor's treatment plan (Beisecker, 1989; Coe & Prendergast, 1985; Ellingson, 2002; Hasselkus, 1992; Rosow, 1981). On the other hand, the chaperone aligns with the doctor when there is a need to act as an interpreter, which he/she achieves by repeating utterances, clarifying details of treatment plans, explaining concepts offered by physicians, and translating the meaning of medical terminology (Ellingson, 2002). The chaperone also contributes by correcting, adding to, or paraphrasing patients' comments (Hasselkus, 1992). In aligning with the physician, the chaperone provides details or supplemental information about the patient (e.g., medical history, the medication used, symptoms experienced, duration of symptoms, and frequency of pain) and also brings up information the patient omitted (Beisecker & Moore, 1994; Barone et al., 1999).

Based on the findings reported above, two critical points are evident. First, the majority of medical studies reviewed as a part of this research concentrated on adult chaperones accompanying geriatric patients, ignoring adult patients. Second, although there is evident paucity of descriptive studies examining the process of alignment formation in triadic medical encounters, there are very limited observational studies that investigated alignment in real-life contexts. Thus, this study aims to address this gap in the body of knowledge by investigating how alignment is developed

in naturally-occurring triadic medical interactions. In other words, the current thesis is designed to answer the following question:

**How does alignment occur in three-party interactions and do chaperones' alignments vary according to chaperone gender?**

With the positive roles played by chaperones in previous research, dominating attitudes are also documented not only by speaking for the patient but also when patient has not been given the primacy to know his/her illness or even which stage of treatment he/she has reached. Such a type of epistemic asymmetry is related to the socio-cultural norms in Saudi society of non-disclosure of diagnosis, as seen in the following section.

## **2.5 What is Epistemic Asymmetry?**

Epistemic asymmetry has two meanings; the first refers to directly controlling the patient's participation by speaking for the patient as if the patient were cognitively impaired. Linell & Luckmann, (1991) argue that asymmetry can be seen as patterns of dominance emerging over sequence management and turn design. Knowledge asymmetry means interactional dominance or asymmetry that is carried out by the third-party when the patient is selected by the physician.

The second meaning of epistemic asymmetry is dominating the patient's access by possessing knowledge and its resources at the patient's expense. This type of epistemic asymmetry is strongly related to Saudi cultural norms of disclosing cancer diagnoses; both the oncologist and the chaperone shares knowledge about a patient's diagnosis without the patient being in attendance. In short, epistemic asymmetry is conceptualised here as violating knowledge norms including: 1) the patient's epistemic primacy (right to know, right to claim), 2) the patient's epistemic access (degree of certainty), and 3) epistemic responsibility (patient's self-experience and external observation; recipient design of actions and turns). Therefore, in order to understand the first aspect of epistemic asymmetry (i.e. controlling patient participation) it is important to review previous medical research about how epistemic asymmetry works in three-party medical interactions.

### **2.5.1. Epistemic asymmetry in doctor-patient-chaperone interactions**

Prior qualitative research (Beisecker, 1989; Clayman, et al., 2005; Coupland & Coupland, 2000; Greene, et al., 1994; Hasselkus, 1992; Mazer, et al., 2014; Tsai, 2007; Vickers, et al., 2015) on epistemic asymmetry in doctor-patient-chaperone interactions was conducted in different encounters, including geriatric clinics (Beisecker, 1989; Clayman, et al., 2005; Coupland & Coupland, 2000; Greene, et al., 1994; Tsai, 2007), oncology clinics (Beisecker, 1989; Mazer, et al., 2014), and diabetes clinics (Greene, et al., 1994; Vickers, et al., 2015). The majority of these studies were conducted in the USA (Beisecker, 1989; Clayman, et al., 2005; Green, et al., 1994; Hasselkus, 1992; Mazer, et al., 2014; Vickers, et al., 2015), although one was conducted in the UK (Coupland & Coupland, 2000) and one in Taiwan (Tsai, 2007).

Findings from these studies indicate that chaperones acted as “surrogate patients” (Beisecker, 1989: 65) or through “pseudo-surrogacy” (Mazer, et al., 2014: 38) by taking over the patient’s role: interrupting the patient repeatedly and answering for the patients most of the time, even when the patient was competent and capable of answering (Beisecker, 1989; Clayman, et al., 2005; Coupland & Coupland, 2000; Greene, et al., 1994; Mazer, et al., 2014; Tsai, 2007). Such controlling behaviour increases the likelihood that physicians view competent patients as impaired or incapable of speaking (Greene, et al., 1994). It has also been observed that doctors, as well as chaperones, talked about the patient rather than with them, referring to the patient as “he” or “she”. Such frequent referral to the patient as “he” or “she” as a result of depending on the third person to provide information reflects the patient’s exclusion from the interaction (Greene, et al., 1994; Mazer, et al., 2014). This in turn, has a great impact on patients by changing their status from the main focus of the visit to a peripheral one (Greene et al., 1994: 418). One of the chaperone’s dominating attitudes in medical consultation is speaking about the patient’s inner experience or external observation without any further confirmation from the patient.

Previous research documented the chaperone’s dominating role when speaking about a patient’s inner, first-hand experiences or a patient’s external observations when discussing prognosis and treatment choices (Coupland & Coupland, 2000; Mazer et al., 2014; Tsai, 2007). In speaking about a patient’s

experience, Mazer et al., (2014) found that in discussing a patient's physical symptoms and shared experiences of events, chaperones made claims about patients' experiences and described events without direct confirmation from the patients as to whether they agreed or disagreed with what their chaperones claimed. Moreover, Tsai, (2007) found that when chaperones report patients' complaints, they lack their direct physical experience of suffering. However, when describing a patient's symptoms, chaperones reported their external observations about the patient's cognitive processes, such as observing their sadness or physical response to the physician's recommendation. Mazer, et al., (2014) found that physicians considered what chaperones say about patients' experiences and their external observations about patient's health as authoritative.

To summarise, in previous research having a chaperone was based on patients' needs; patients were less educated and in worse physical health (Beisecker, 1989; Clayman, et al., 2005; Greene et al., 1994; Tsai, 2007). These factors increased the likelihood of the chaperone to dominate the medical interaction at the patient's expense. Dominating the medical encounter is not the only aspect of knowledge asymmetry but also when cultural norms do not give patient the right to be aware of his or her illness. Breaching patient's epistemic primacy is discussed in the following part.

### **2.5.2. Breaching the patient's epistemic primacy**

Another form of knowledge asymmetry is when the relative epistemic status of the patient's illness is shared between the oncologist and the chaperone without the patient, whose primary right is to own knowledge about his/her illness. Such a feature of knowledge asymmetry is called "non-disclosure", which mostly occurs with cancer patients in oncology departments.

Having epistemic entitlement to access cancer diagnosis and make decisions about medical care are two important issues of patient autonomy in biomedical ethics which originally emerged in the United States (Khalil, 2013), and have become deep-rooted in many western societies (Hoff, et al., 2007; Karim, et al., 2015; Salander, 2002; Surbone, 1997). However, these ethical values of patient autonomy have not yet become important in Middle Eastern societies, particularly in Saudi Arabia

(Aljubran, 2010; Khalil, 2013) with respect to non-disclosure of cancer diagnosis. In Saudi Arabia, it is believed that honest disclosure and telling the patients the truth about the diagnosis, treatment, and prognosis of cancer may adversely lead to their distress, loss of hope, and earlier death (Aljubran, 2010; Karim, et al., 2015; Young et al., 1997). Prior research, in western and non-western countries, has empirically investigated patients' perceptions (Al-Ahwal, 1998; Al-Amri, 2009; Aljubran, 2010; Karim, et al., 2015; Mereith, et al., 1996); physicians' perceptions (Chittem & Butow, 2015; Holland, et al., 1987; Mobeireek, et al., 1996, 2008; Ozdogan, et al., 2004); and chaperones' perceptions (Ozdogan, et al., 2004; Shin, et al., 2014) regarding communicating bad news about cancer. The majority of cancer patients prefer to have full epistemic access about their health and disease (Meredith, et al., 1996). In Karim et al.'s study (2015) the majority of Saudi cancer patients (98%) preferred to receive as much information as possible about their condition's diagnosis, treatment, results of the treatment and progress. Similarly, between 2002 and 2005 Al-Amri (2009) recruited 114 Saudi cancer patients to carry out a structured interview-based study before they knew their diagnosis. All patients except one wanted to receive a truthful disclosure about their illness whereas the remaining other wanted to have partial disclosure, and all of them rejected withholding information. However, Al-Amri (2010) assessed the attitudes of 332 male and female cancer patients' from the eastern region of Saudi Arabia, towards the disclosure of cancer information via a questionnaire. 70% of Saudi female cancer patients wanted their chaperones to have more information about their illness than them compared to 39% of Saudi male cancer patients.

Although physicians in some cultures, particularly Middle Eastern societies, believe that patients have authority and epistemic entitlement to know their illness and treatment plan which will help them to move along the different stages of their journey, they are more likely to follow the chaperones' wishes to not tell the patient the truth (Karim, et al., 2015; Ozdogan, et al., 2004). However, previous research in Saudi Arabia shows there have been disparity and a source of conflict in physicians' perceptions in communicating serious illness. For example, Mobeireek, et al., (1996) recruited 249 senior and junior physicians to carry out a questionnaire-based survey in Saudi Arabia. 75% of the participant physicians preferred to discuss bad news with

chaperones rather than the patient, (even if the patient is mentally competent). Less than 47% of oncologists preferred to talk to the patients regarding their diagnosis and prognosis of their serious illness. However, in a survey of 321 physicians from different regions in Saudi Arabia, only 67% of physicians reported that they would prefer to inform the patient of the diagnosis of the incurable illness in preference to telling the family. 56% of the physicians reported that they would inform the chaperone without the patient's consent (Mobeireek, 2008).

As far as chaperones' experience is concerned, there is limited previous research documenting their attitudes regarding the disclosure of a cancer diagnosis (Ozdogan, et al., 2004; Shin, et al., 2014; Zamanzadeh, et al., 2013). There has been a consensus in chaperones' attitudes in previous research (Ozdogan, et al., 2004; Zamanzadeh, et al., 2013), that they opposed disclosure of cancer diagnosis for various factors. They believed that the disclosure of cancer would lead to the patient's severe distress, reduce the effectiveness of the treatment plan, and increase the chance of cancer recurrence.

In addition, there are other factors that are against the disclosure of cancer diagnosis to patients in Saudi Arabia as discussed below.

#### **2.5.2.1. Non-disclosure from the Saudi perspective**

There are different factors that contribute to non-disclosure, two of which are medical and socio-cultural backgrounds. From the medical perspective, cancer was and still is seen as a serious, life-threatening, even terminal illness which is perceived in many societies as the untreatable illness (Kazdaglis, et al., 2010; Stark and House, 2000) and thus leading to death. Cancer, with its frightening name creates fears, dread, anxiety, and suffering among both healthy and ill Saudis (Al-Amri, 2010; Bedikian & Saleh, 1985; Bedikian & Thompson, 1997; Ibrahim, et al., 1991). The word for "tumour" in Arabic is "waram" which has the same meaning as in English, i.e. "swelling", which can be either benign or malignant (Younge, et al., 1997). However, most people in Saudi Arabia think that tumours are benign (Holland, et al., 1987; Younge, et al., 1997). Local tradition has implicitly used two terms to describe types of tumour as "male" for malignant and "female" for benign (Younge, et al., 1997).



The Arabic word for cancer is “saratan”, which also means “crab”; giving a feeling of a strange and frightening appearance of a monster with many arms, to harm others (Younge, et al., 1997). Undoubtedly, western and non-western societies share the same fear of cancer diagnosis (Holland, et al., 1987; Mizuno, et al., 2002; Younge, et al., 1997). Two studies (Bedikian & Thompson, 1985; Ibrahim et al., 1991) sought the attitudes of healthy Saudis towards the concept of cancer, and both studies reveal a high level of fear, anxiety, and misconception of cancer as an incurable disease that commonly leads to death.

From the socio-cultural perspective, although patient autonomy and informed consent are legally and ethically two important values in building doctor-patient relationships in western countries, and in the Far East, e.g. Japan (Okamura, et al., 1998), both issues are not prominent in Saudi society (Aljubran, 2010). Patients are viewed as an extended family, chaperones are religiously and culturally obliged to help and support their sick relatives by taking over some or all of the patients’ responsibilities to show their support and sympathy towards them (Aljubran, 2010). They assume that their ill relatives, particularly women, are weak and should not be left alone with the oncologists to experience hearing painful and difficult facts (Aljubran, 2010). Unfortunately, such family chaperones’ supportive attitudes may gradually develop into a dominating position that breaches the patient’s own right of knowledge and decision making (Aljubran, 2010).

Most old women trust such dominating behaviour from their chaperones (mostly sons), and thus hand over some, or all responsibilities (Aljubran, 2010). Therefore, chaperones ask physicians to withhold or sometimes modify any unfavourable information given to patients, or just tell less than the truth (Al-Amri, 2010), especially if the patients are keen to know more about drugs and diagnostic procedures. Breaching the patient’s epistemic entitlement in this way is a contradicting situation for the health care providers; between what they have learned in terms of the ethics of medicine and what their socio-cultural background requires (Al-Amri, 2010; Aljubran, 2010).

In certain situations, withholding cancer information in particular circumstances is deemed ethically justifiable. One of these is if the physicians have firm evidence that disclosing truthful information would create real and potentially

harmful effects on the patient (e.g. committing suicide). In this case withholding a terminal diagnosis from the patient may be appropriate (Al-Amri, 2010; Drane, 2002; Ethics in Medicine, 2011). The second reason is that, if the patient does not give informed consent to their chaperone to be told about their diagnosis, their preference should be respected (Ethics in Medicine, 2011). Therefore, the doctor should balance between telling the truth without causing harm (Surbone, 1992), or deliberately withholding information without lying to or deceiving (Al-Amri, 2010) the patient. Otherwise, doctor-patient trust is lost.

In summary, based on the findings of previous research on epistemic asymmetry, a number of critical remarks should be added here. First, the majority of previous studies were quantitative, using questionnaire methodology (Chittem & Butow, 2015; Holland, et al., 1987; Karim, et al., 2015; Mobeireek, et al., 1996, 2008; Ozdogan, et al., 2004; Shin, et al., 2014) and only one was qualitative with semi-structured methodology (Zamanzadeh, et al., 2013). Second, the literature on knowledge asymmetry in medical interaction has primarily focused on physician-patient relationships (Kettunen, 2006; Landermark, et al., 2015), leaving the impact of the oncologist's and chaperone's non-disclosure of patient's cancer diagnosis relatively unexplored. Third, there are surprisingly no observational studies that show how patient autonomy and primacy is breached by chaperones and physicians in third-party interaction. In other words, up until now no study has investigated how the patient's entitlement to diagnostic disclosure is breached in a real-life context. Therefore, the fourth research question that the current research attempts to answer is:

### **How is epistemic asymmetry managed in triadic interactions?**

## **2.6. Summary**

In this chapter I have reviewed previous research concerning the third-party in medical encounters. I have addressed several lacunae in three-party literature by investigating three-party medical interaction in Saudi Arabia from different perspectives, i.e. patient satisfaction, patient perceptions, alignment and epistemic asymmetry, and by including the Saudi female patients from different age groups. Thus, my study aims to answer the following research questions:

1. What are the factors that influence patient satisfaction in three-party interaction?
2. What are the perceptions of the Saudi female patients regarding their chaperones' roles during their medical visits?
3. How does alignment occur in three-party interactions?
4. How is epistemic asymmetry managed in triadic interactions?

In the following chapter, I will describe the qualitative and quantitative methods used to address these questions.

## **CHAPTER 3**

### **Methodology**

#### **3.1. Introduction**

The aim of this study was to understand three-party interactions in Saudi Arabia. In the previous chapter, the main themes pertaining to three-party interactions, (i.e. patient satisfaction, patients' perceptions, alignment and epistemic asymmetry) are established. These issues need to be explored, more specifically, the study attempts to answer the following research questions:

1. What are the factors that influence patient satisfaction in three-party interaction?
2. What are the perceptions of the female patients regarding their chaperones' roles during their medical visits?
3. How does alignment occur in three-party interactions?
4. How is epistemic asymmetry managed in triadic interactions?

The questions outlined above include a variety of areas that need investigation: not only patient satisfaction and patient perception regarding the three party interactions but also how three-party interactions are practised in reality. As shown in Chapter Two, although the contribution of previous studies on three-party literature is acknowledged (Andrades et al., 2013; Glasser et al., 2001; Speice et al., 2000), their findings are often based on one method. Consequently, they do not offer a complete picture regarding three-party interactions with their complex issues such as epistemic asymmetry (Aljubran, 2010). The current project attempts to investigate these issues by using a mixed method design to develop in-depth understanding of three-party interactions in Saudi Arabia. Therefore, the aim of this chapter is to discuss the methodological procedures employed in designing and collecting data to answer the four research questions.

In this chapter I will only concentrate on the methods of collecting qualitative and quantitative data associated with the ethical issues implemented in this research, the problems encountered during data collection and issues relating to the trustworthiness measures of qualitative research employed in this study. For the data

analysis procedures I undertook in the current research for both the qualitative or quantitative data, I have discussed the steps to analyse each qualitative or quantitative data method in its main analytical chapter in order to be more focused and not to cause confusion by including everything in this chapter.

For the construction of this chapter, in section 3.2, I present the rationale behind conducting mixed methods research. In section 3.3, I describe how I collected the data for the current research. I also provide a description of how I obtained access to the healthcare settings in 3.3.1. Next, I move on to describe how I collected the qualitative data by discussing first my preliminary observation (in section 3.3.2.1) which helped me to collect the actual audio-recording data from the three hospitals in Saudi Arabia mentioned in section (3.3.2.2). In section, 3.3.3, I discuss the procedure of collecting the quantitative data by first explaining how the questionnaire was piloted and then how the actual questionnaire data was collected. I refer to study setting and the participants in 3.4. I discuss ethical consideration such as gaining informed consent and ensuring participant confidentiality in 3.5. I present problems encountered during the data collection process in 3.6. Finally, I mention the four measures employed in the current research to establish the trustworthiness of the qualitative data in 3.7. I finish by summarising the main points discussed in this chapter in 3.8.

### **3.2. Mixed Methods**

The methodology of mixed method was adopted for this study in order to explore four main themes in doctor-patient-chaperone interaction: patient satisfaction, patients' perception of their chaperones, knowledge asymmetry, and alignment. The mixed methods design includes "the collection or analysis of both quantitative and qualitative data in a single study in which the data is collected concurrently or sequentially, are given priority, and involves the integration of data at one or more stages in the process of research" (Creswell, et al., 2003, p. 212). More specifically, the primary mixed method design adopted in this study was convergent design.

The convergent design is the most popular mixed method approach discussed by scholars from different disciplines (Jick, 1979). This design has been known in

literature by different names, such as “triangulation,” which is often confused with triangulation in qualitative research.<sup>4</sup> Other different names by which this design is known are “simultaneous triangulation” (Morse, 1991), “parallel study” (Tashakkori & Teddlie, 1998), and “concurrent triangulation” (Creswell, et al., 2003). The research design employed in this study comprised of qualitative observation, followed by a quantitative post-visit self-administrated questionnaire. In a single-phase design, both qualitative observation and quantitative questionnaire completion are performed simultaneously, but are analysed independently using typical qualitative (i.e., conversation analysis and thematic analysis) and quantitative analytic procedures (i.e., statistical tests) (Creswell & Clark, 2011). Due to this sequential approach, the results of one method do not depend on the other. During the overall interpretation of the merged results, the results from both data sets are combined and compared in order to discuss in what ways the results from the two types of data pertaining to three-party interactions converge, diverge, relate to each other in order to produce an in-depth understanding (Creswell & Clark, 2011), as outlined in the flowchart presented in Figure 3.

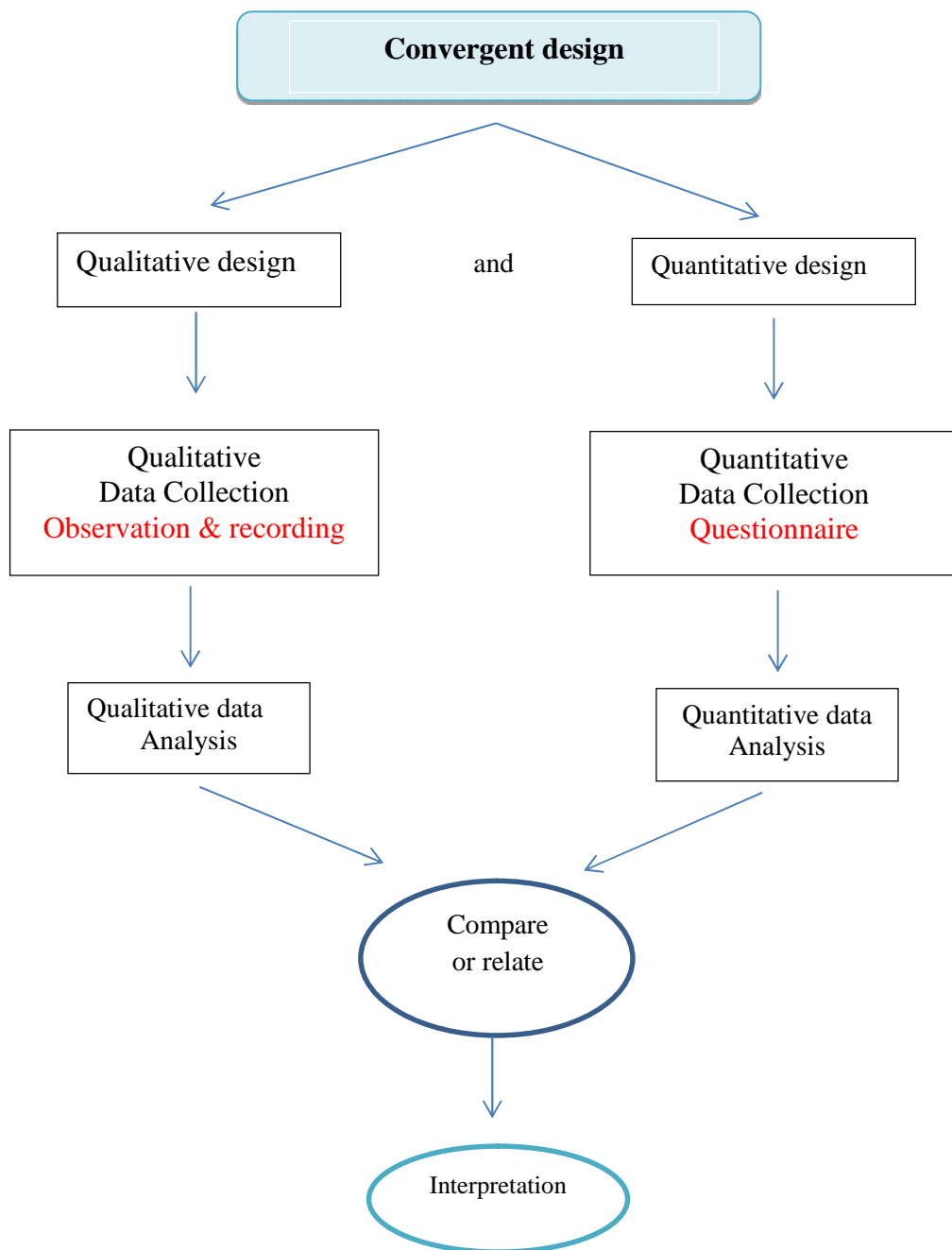
The rationale for using the convergent design in this project was twofold. First, the majority of studies on three-party interactions adopted either a quantitative (Greene, et al., 1994; Shields, et al., 2005; Street & Gordon, 2008; Wolff & Roter, 2008) or a qualitative approach (Beisecker & Moore, 1994; Hubbard, et al., 2010; Kimberlin, et al., 2004; Speice, et al., 2000), with only one study following the mixed methods approach to explore three-party interactions (Laidsaar-Powell, et al., 2013). Therefore, the aim was to develop a complete understanding of doctor-patient-chaperone interactions in Saudi Arabia, via multiple approaches, using qualitative and quantitative data, rather than relying on either method in isolation. Second, a mixed method design was employed to present “a greater diversity of divergent views” (Tashakkori & Teddlie, 2003, p. 676) by answering different research questions. Thus, the results from one method, combined with those yielded by the other, provide an opportunity for more elaboration, enhancement and clarification and “increase interpretability, meaningfulness and validity” of the

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<sup>4</sup> Triangulation in qualitative research implies using two or more methods to produce equivalent results and to increase the credibility and validity of the study findings (Morgan, 2014).

findings (Greene, et al., 1989, p. 259), allowing the study to make a distinct contribution to the pertinent literature. Therefore, by answering the research questions, the mixed methods allowed the appreciation of a full picture of three-party interactions in Saudi Arabia, since such studies have not previously been conducted in the Middle East, particularly in Saudi Arabia.

**Figure 3.** Model of data collection and data analysis adapted from Creswell and Clark (2011)



Although convergent design has insightful advantages that either quantitative or qualitative methods cannot provide when used on their own, it has certain methodological limitations as suggested by Creswell & Clark (2011). First, convergent design requires expertise and considerable effort in collecting both quantitative and qualitative data at the same time. Second, it can be difficult to merge and compare the results from two independent sources in a meaningful way. Third, it can be challenging for the researchers to resolve contradictions and discrepancies that arise while comparing the findings, i.e. when the two methods do not produce equivalent results.

The following section presents a thorough description of the methods used in the data collection process.

### **3.3. Methods of Data Collection**

The first step in designing the methodology of the present study was to gain access to any possible healthcare locations where a third person (i.e. patient's chaperone) was available in the consultation room. The second step was to conduct a preliminary observation, then to observe and collect a good quality as well as a naturally occurring medial interaction recommended by Conversation analysts (ten Have, 1999). The third step was to collect post-visit questionnaire data. These phases are discussed in the following sections.

#### **3.3.1. Negotiation of healthcare access**

Obtaining access to the healthcare settings in Saudi Arabia was the initial step in conducting this research. Thus, gaining approval from the Research Ethics Committee (REC) was an important requirement, without which I would not have been able to collect the required data from the hospitals run by the Ministry of Health. Thus, in August 2010, I sent emails to four governmental as well as four private hospitals in two cities in Saudi Arabia—Jeddah (where I live and work) and Abha (where my family resides). In this initial email, I clearly stated that I am a Saudi female PhD researcher interested in studying the characteristics of three-party interactions that take place during a hospital appointment. I also stated the methods I



would employ when collecting the medical data, and proposed that I commence the preliminary observation in September 2010. Three private hospitals welcomed the idea of serving as a research site and asked me to complete a research application, as well as provide the following documents: proof of studentship, a letter from my supervisor, my curriculum vitae, my study proposal and a consent form to be signed by the study participants. One of the private hospitals apologised for not accepting my invitation to partake in the study, as their primary interest was clinical research, while my study was behavioral in nature. Another research committee member advised me to come in person, rather than communicating via email, as this would expedite the approval process.

In the last week of September 2010, having failed to obtain a positive response regarding my application, I decided to visit each hospital personally. During that time, I met the head of the Research Centre in three hospitals and resubmitted the application both electronically and manually.

After gaining the formal ethical clearance from the Ethics Research Committee of each hospital in October 2010 (see Appendix 1 & 2), I started contacting the chairmen of each medical department, making an appointment with each one, and subsequently arranging—with the help of the secretary of each department—contact with the physicians. The purpose of this meeting was to conduct the second phase of my research, namely preliminary thorough observation that would last one week.

### **3.3.2. Observation and audio-recording**

#### **3.3.2.1. Preliminary observation**

After obtaining permission to conduct the study on the premises of the aforementioned hospitals, I started a week-long preliminary non-participant observation without recording the consultation. The objective of this phase was threefold: (a) to gain a better understanding of the context in which the three parties are interacting in the consultation room; (b) to familiarise myself with the overall structural organisation of a medical consultation, such as presenting complaint, examination, diagnosis, and treatment (Heath, 1984; Heath & Luff, 2000); (c) to minimise the intrusion of my presence, known as “observer paradox” (Labov, 1972,

p. 256) (for full discussion see 3.3.2.2.) inside the consultation room by finding the least obtrusive place to sit.

In the light of these reasons, I decided to conduct the preliminary observation myself, acting as a non-participant observer. This meant that I was not taking part in any medical activity inside the consultation room. During the week-long preliminary observation, I was able to understand the structural organisation of the hospitals and the medical visit. Moreover, I identified the least unobtrusive place to sit in the consultation room, which was in the right-hand corner opposite the clinic door. It is important to note that previous preliminary observation played a role in selecting which clinics to collect the data from, particularly for the orthopaedic and oncology departments<sup>5</sup>. Once the preliminary observation was completed, the next phase of the data collection process could commence, comprising observing as well as audio-recording the consultation.

### **3.3.2.2. Audio-recording and observation**

#### **3.3.2.2.1. Background (strategies of data collection)**

After receiving the ethical approval from the University of Edinburgh and my sponsor King Abdulaziz University to start data collection, the two private hospitals were contacted through email regarding the approval I received from both institutions. Copies of the ethical approval from each institution<sup>6</sup> (see Appendix 1& 2) and the fieldwork plan were sent to the Research Centre in both hospitals. The fieldwork plan included the procedures that I had to follow every week and the required number of participants I had to collect (20 female and 20 male chaperones in each hospital).<sup>7</sup> In response to that initial communication, I received an email from the head of the Research Centre in both hospitals, confirming that their staff would assist me in the data collection process. The data collection commenced on November 17th, 2011 and ended on February 16th, 2012. The data collection

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<sup>5</sup> The rationale behind this is related to the quick-response emails I received from the physicians who displayed their willingness to participate as opposed to other departments.

<sup>6</sup> I had to renew the ethical clearance I received from the two private hospitals in 2010.

<sup>7</sup> Unfortunately, after three weeks working in the two private hospitals, I was obliged to leave the hospitals because of the low number of Saudi female patients along with their chaperones coming to these hospitals. Thus, I explained my reasons (time constraints) for leaving these hospitals to continue data collection at a governmental hospital (see Appendix 3 for the received ethical approval) to the Head of the Research Centre in both hospitals and sent a detailed report of my fieldwork and the problems I encountered in both hospitals.

process was divided into two parts: (a) a one-week pilot study and (b) data collection (November 2011 to January 2012). During the data collection, I visited either one hospital in one day or two on the same day<sup>8</sup>.

As mentioned in Chapter One, the highest proportion of healthcare services in the governmental sector is provided for the Saudi citizens (see 1.4.2.). Thus, due to the significant number of patients that met the study inclusion criteria in the governmental hospital (H3), I was able to collect data from 102 individuals within two months (see Appendix 4 for the calendar of visits to the three hospitals in Jeddah). Several factors were instrumental in this process, in particular: (a) a much greater number of Saudi female patients receiving free of charge treatment in the governmental hospital compared to those that attend private hospitals, as many Saudi patients cannot afford the expense; (b) female patients in the governmental hospital are usually accompanied by a chaperone allowing for the variation of chaperone gender to be explored in this study; whereas in private hospitals patients tend to come alone<sup>9</sup> to the clinic; (c) the data collection was assisted by the significant involvement of the Research Centre staff in H3, in particular, the active Saudi nurses. They immediately informed me when Saudi female patients had registered their presence, in case I was busy with another patient. Their help was instrumental, as my data collection involved 11 clinics in the Oncology Centre. Thus, it was helpful that the nurses assisted me in determining the number of patients I would observe every day and the amount of time I had between patients.

During the fieldwork, I always arrived early (i.e., an hour before the clinic began). I wore a white lab coat (in H3) or the hospital uniform (in H1 and H2) with a hospital photo ID attached to the left side, which identified me as a university-affiliated researcher<sup>10</sup>, in order not to confuse me with the hospital personnel. On my arrival, I always checked the outpatient appointment list (see Appendix 5) at the nurse station, in order to determine the number of the Saudi female patients coming

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<sup>8</sup> Note that there were clinics in the governmental and private hospitals starting from 9.00 a.m.-1.00 p.m. However, more flexible clinics in the private hospitals started from 1.00 p.m.-9.00 p.m. Others were from 5p.m.-9.00 p.m.

<sup>9</sup> Since a nurse is available in the medical room with the doctor, there is no need for a chaperone.

<sup>10</sup> Sometimes, some patients asked my advice regarding their illness or the medication they had been taking. In these cases, I always stressed that my position as a researcher prohibited me from providing any medical advice.

to their appointments on that day. I took their names, in order to be able to approach them and greet them appropriately.

Two strategies were adopted in approaching the patient. The first—aimed to increase the participation rate—involved being introduced to the patients<sup>11</sup> in the female waiting area in H3 by a nurse from the Research Centre in the hospital. I was introduced as a PhD candidate, studying at Edinburgh University, and a Saudi female researcher from King Abdulaziz University. If the patient showed interest, I continued by briefly explaining my research to the patient and asking whether she would like to participate in the study. I made sure that the patient understood that I was primarily interested in how a male doctor interacts with female patients in front of their chaperones. The patient was also informed that the participation in the study involved tape-recording the interactions during the consultation and completing a short post-visit questionnaire (see questionnaire collection in 3.3.3). If the patient agreed to the above, I read the consent form aloud, in order to obtain her informed voluntary consent to take part in the study. Finally, I answered all the patient's questions and repeatedly reassured her that data confidentiality and her anonymity would be maintained at all times (see ethical considerations in 3.5). This approach<sup>12</sup> was extremely helpful, as it resulted in many patients agreeing to take part in the study.

The second participant recruitment strategy was to directly approach each patient whose name was registered on the outpatient list (see appendix 5) and who confirmed her attendance at the nurse station. I would approach the patient and ask her name for confirmation, before asking whether she was accompanied by a chaperone. If she confirmed that she had a chaperone, I would introduce myself (either at the nurse station or in the female waiting area), giving both the patient and her chaperone a brief description of my research project. I would then briefly explain the data collection procedure, and ask whether they were interested in taking part in the study. If the patient was willing to participate, I would provide the

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<sup>11</sup> In H3, 102 female patients participated in the study, of whom 67 (65%) came from distant towns and villages to receive free healthcare from the National Health Service (NHS). Most of the patients came at least an hour before their appointment was scheduled.

<sup>12</sup> Although this approach was used with new patients, some follow-up patients that already knew me informed the new patients of my work, which made them more willing to participate in the study.

observation sheet<sup>13</sup> (see Appendix 6), which ascertained whether the patient and her chaperone were eligible for participation. If the inclusion criteria were met, and both the patient and her chaperones consented, they signed three copies of the consent form (the English version is produced in Appendix 7 while the translated Arabic version is given in Appendix 7a, [see ethical consideration in 3.5]).<sup>14</sup>

However, if the patient was accompanied by a male chaperone, a different procedure had to be followed. As before, the patient was approached in the female waiting area, and if she agreed to take part in the study, consent was sought from her male chaperone who was approached in the male waiting area. Sometimes, I asked the patient to come outside with me, where I called her male chaperone and discussed the study and his involvement in front of her. If both decided to take part in the study, the previously described process of completing the observation form and obtaining the consent was followed. When the nurse called the patient's name, it was time for the patient and her chaperone to enter the consultation room in order for me to start the first part of data collection, namely, observation and audio-recording the three-party interactions.

#### **3.3.2.2.1.1. Audio-recording**

In order to answer the third and fourth research questions, samples of naturally occurring three-party medical interaction were important. Such samples needed to involve the Saudi female patient, her male physician, and her chaperone (male or female). In this section, I will describe how I collected audio-recordings of the three-party interactions.

When the nurse called the patient's name<sup>15</sup>, I accompanied the patient and her chaperone to the medical clinic. Before arriving in the room where the appointment was held, I switched on the audio recording equipment, in order not to miss the opening sequence of the clinic. Upon entering the clinic, I placed the tape recorder

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<sup>13</sup> The information on the observation sheet included the name of the hospital, date, name of the clinic, name of the doctor, patient's name, chaperone's name, chaperone's relation to the patient, the city/town where the patient came from, and reasons for the visit. This helped a lot in interpreting the data, particularly in the patient perception chapter (see Chapter Six).

<sup>14</sup> According to the Saudi Biomedical Ethics and Hospital Policy, three copies of the consent form must be obtained, one of which is given to the patient, one inserted in the patient's file, and one kept for the researcher's record.

<sup>15</sup> I usually sat either in the female waiting area or at the nurse station until the patient's name was called.

on the physician's office<sup>16</sup>. It is important to mention that I was present during all of the observations in three hospitals to monitor the audio equipment as well as to observe the three-party interactions.

The reasons for conducting audio recordings of medical consultations rather than video-recordings were due to several factors. First, audio-recording<sup>17</sup> is necessary to collect a naturally occurring three-party medical interaction in order to address the main qualitative research questions of this thesis. Second, this was based on the recommendation of the medical manager of one of the private hospitals who explicitly stated that the physicians of their hospital would feel comfortable being audio-recorded rather than being video-recorded<sup>18</sup>. Third, videotaping a Saudi female patient in the presence of her male doctor and her chaperone in a medical consultation in Saudi Arabia, a very conservative Islamic country, is completely forbidden and against the law of the Saudi society. Fourth, audio devices are cheap, portable, and unnoticeable, and they can easily be set up without checking the clarity and inclusion of the picture (Macdougall & O'Halloran, 2001; Knox, et al., 2002). Fifth, audio-recording equipment is less intrusive and less disruptive than camera equipment.

With regards to the number of collected recordings, I was able to obtain a total of 117 medical recordings from the three hospitals—the majority came from the governmental hospital, (H1= 13, H2= 2, H3= 102)—about 120 hours of data (see appendix 8 for the calendar of audio-recording of medical consultations in the three hospitals).

Although audio-recording has vital advantages in recording natural actual data, it has certain limitations, one of which is what Labov (1972) calls the 'observer's

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<sup>16</sup> During audio-recording I kept notes of three-party behaviours, seat placement, and unusual behaviours of either the chaperone or the patient. For example, a patient was pointing non-verbally to the audio-recording for the doctor to be aware that the conversation was being recorded.

<sup>17</sup> To ensure good quality recordings of three-party medical consultations, I used a Zoom H2 Handy Recorder. This equipment saved audio files as either MP3 or WAV onto a removable SD card. The Zoom H2 audio recorder was small, portable, and protected by a leather padded pocket. It was also easy-to-use, less intrusive, able to record a good quality medical discussion from the front and back sides simultaneously, and easily separated recorded files.

<sup>18</sup> What is interesting here that some physicians might think that recording was used to evaluate their attitude to the patient in the medical consultation although the consent form explicitly stated the purpose of recordings. One physician asked my opinion regarding his consultation after the observation process.

paradox'. This refers to the observer's effect on the participants' behaviours. It means that the participants may alter their natural behaviour or talk because they are being recorded and watched. As seen in Extract 3.1 below, a change in behaviour was observed during my first visit to hospital 1, particularly in the Orthopedic Surgery clinic, where the Orthopedic Consultant warned the female patient and her husband that their conversation would be recorded (lines, 3 & 7) and thus they had to discuss issues in medicine only.

**Extract<sup>19</sup> 3.1. (H1 V9 D4 Da. 10/12/2011. Surgical. Orthopaedic.) (P: 43; her husband: 45)<sup>20</sup>**

- ((Doctor entered the clinic))
- 1 Dr. ha ya duktu ra ki f a lik<sup>21</sup>?=
- 2 Res. = al-la h yisalmak ki f a lak ya duktu r? Hhh,
- 3 Dr. → aysajilu u tana [°kaama n ££££° =
- 4 M.ch. = [mm]=
- 5 ((The doctor closed the clinic door ))
- 6 Res. = huhuhuh=
- 7 Dr. → = i na ma -nik ani-tkalam ba bil bil ib bas
- 8 (( the surgeon is walking towards his office))
- 9 ((The surgeon sat down))
- 10 Dr. aya ki ki f a lik fatma ?
- 
- ((Doctor entered the clinic))
- 1 Dr. Hey doctor how are you?=  
 2 Res. =Thank God how are you doctor? hhh,  
 3 Dr. → They are recording our voices [°as well ££££° =  
 4 M.ch. = [mm]=  
 5 ((The doctor closed the clinic door ))  
 6 Res. = huhuhuh=  
 7 Dr. → = we will not tal-k will talk about medicine only  
 8 ((the surgeon is walking towards his office))  
 9 ((The surgeon sat down))  
 10 Dr. How are you Fatma<sup>22</sup>?

To overcome this problem, some scholars (Gillis & Jackson, 2002) suggested two methods to minimise such a change in behaviour. The first method is for the researcher to spend a prolonged time in the field site. The second method is that the

<sup>19</sup> The extract's number is chronologically organised according to its placement in each chapter. As Chapter 3 starts with the first extract so its number is 3.1. The same procedure is followed for the rest of the extracts in chapters 6 and 7.

<sup>20</sup> (See Appendix 9 for a list of abbreviations and Appendix 10 for a list of transcription conventions).

<sup>21</sup> (See Appendix 11 for the IJMES transliteration system of Arabic consonants and vowels).

<sup>22</sup> Fatma is pseudonym.

researcher should help the participants to relax and reassure them that their conversations will be used anonymously. Following these suggestions, I spent two months in observing hospital 3, and three weeks in hospital 1 and 2. In addition, the participants were informed from the beginning that the observational data was confidential and would not be shared with anyone and it was only used for academic purposes. They were also informed that their names and locations would be anonymous and suppressed. As a result, with the passage of time<sup>23</sup>, the participants' conduct seemed to ameliorate; participants became used to audio-recording and most of the time they forgot that they were being observed. Therefore, four extracts like the one above were disregarded from the data in which the participants' conduct was unnatural.

After recording the three-party interactions, I immediately started the second part of the data-collection, i.e. the post-visit questionnaire as explained in the section below.

### **3.3.3. Questionnaire data**

This part has sub-sections. In the first part, I will explain the phase of piloting the questionnaire, and in the second part I will describe the actual collection of the questionnaire data.

To answer the first research question about the factors that influence patient satisfaction in three-party interaction, a self-administrated questionnaire is used for measuring patient satisfaction in three-party interactions. Although there are no universally applicable methods for measuring patient satisfaction (McMillan, 1987), the most practical and widely used data gathering strategy is a self-administrated questionnaire (Ford, et al., 1997; Ware, 1981). Questionnaires can either be distributed by mail or offered to patients during the healthcare encounter. As mailing the questionnaire often results in a low response rate, a direct face-to-face interview with the patients is highly recommended (French, 1981). This approach allows the healthcare provider to better assess the quality of care or other dimensions of patient satisfaction.<sup>24</sup>

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<sup>23</sup> Some patients were informed of my project by the ones who were previously observed.

<sup>24</sup> These include accessibility/convenience, finances, physical environment, and availability (Ware, 1981, pp. 894-895)



In the following section, I will explain the procedure of piloting the questionnaire before commencing the actual data collection.

### **3.3.3.1. Piloting the questionnaire**

Piloting is extremely important because it allows the researcher to amend the problematic areas and refine the questionnaire. The questionnaire utilised as a data collection instrument in this study was piloted in H1 only, (in orthopaedic surgery clinics with 10 patients), as the required data was not available in H2<sup>25</sup>.

The individuals included in the pilot study were similar to those that were subsequently included in the main enquiry. Moreover, the participating patients were also verbally asked to provide their opinions regarding the clarity of the questionnaire items and identify any problem areas relating to the time, content, wording, layout, and instructions. Following Marshall's (2005) and Oppenheim's (1992) guidelines, the participating patients were asked the following questions:

1. Is the questionnaire too long?
2. What do you think about the length and layout of the questionnaire?
3. Are the questionnaire instructions and answer categories clear to you?
4. Have you faced difficulty in answering certain items in the questionnaire?
5. Is the time allocated sufficient to complete the questionnaire?
6. Do you have any additional comments regarding the content or wording of the questionnaire?

In the light of the pilot study results, the questionnaire was refined (i.e. some changes in wording but nothing substantive) as noted above, and was deemed suitable for use in the final data collection.

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<sup>25</sup> In the first week of the pilot study in H1 and H2, I was advised to look for a governmental hospital, as the type of data I was looking for was not always found in the private hospitals, where the majority of the female patients were either non-Saudi or Saudi that came without chaperones. At that time, I only had the approval to conduct the study in these two private hospitals. However, as it was difficult to find sufficient number of accompanied Saudi female patients, especially in H2, I had to urgently identify a governmental hospital that could serve as a site for my research. Therefore, approval from the governmental hospital was granted on December 4th (see Appendix 3)

### **3.3.3.2. Administrating questionnaire**

The questionnaire (the English version is produced in Appendix 12 while the translated Arabic version is given in Appendix 12a) was administrated by the researcher during the process of data collection. For example, when the consultation was finished, I gained permission from the patient's chaperone to wait while the patient went with me to the female waiting area (or somewhere else) to complete the questionnaire. The female patients had to be away from their chaperones to ensure that they independently responded to all items truthfully. It is important to note that patients who consented to participate in the study filled out the first two parts (i.e. demographic information about the patient and her chaperone, e.g., age, level of education, etc.) of the self-administrated questionnaire before the consultation, while the rest of the questionnaire was immediately completed after the consultations. Therefore, the questionnaire was completed in the female waiting area, the inpatient chemotherapy room, or the waiting area in front of the blood laboratory.

Illiterate patients and those who were undergoing treatment (some patients were seen in the inpatient chemotherapy room, or in the medical laboratory while waiting to have a sample of blood taken, and needed my help in completing the questionnaire) were helped to complete the questionnaire by the researcher. In such cases, the researcher read aloud each item and, if necessary, paraphrased the question, for clarification. Completing the questionnaire with the patient usually took about 5-10 minutes.

In order to better understand the medical settings where the data was collected and the participants who took part in the current research, the section below gives a detailed description of this.

## **3.4. Study Setting and Participants**

### **3.4.1. Settings**

The study setting consisted of 20 medical clinics in two private (henceforth referred to as H1 and H2)<sup>26</sup> and one governmental (H3) hospitals in Jeddah, the second largest city in the western region of Saudi Arabia, after the capital. These clinics were General Surgery (1), Orthopaedic Surgery (5), Chemotherapy (4),

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<sup>26</sup> The data collection in the two private hospitals ceased by the third week, as there were insufficient cases suitable for inclusion.

Haematology (2), Radiotherapy (2), Surgical Oncology (5), and Nuclear Medicine (1). The rationale for conducting the study in these hospitals was based on (a) their geographical location and their capacity; (b) the response emails I received from the representatives of these hospitals expressing their willingness to participate in the study. Hospital 3 (H3) was an excellent study site where the majority of the required data was found, unlike the two private hospitals where the majority of the female patients were either non-Saudi or came alone.

In the following section, a brief account of the healthcare services provided by the private and governmental hospitals is given.

#### **3.4.1.1. Private hospitals (H1 & H2)**

The private hospitals (i.e., H1 and H2) are considered tertiary referral hospitals. Both provide comprehensive, preventive, as well as therapeutic healthcare services at all levels of care (primary, secondary, and tertiary referrals). The two private hospitals comprise of many clinical departments with sub-specialities and several centres run by the US, Canadian and European Board of Certified Physicians. In addition, both hospitals provide advanced medical services, such as open-heart surgery, kidney transplants, and bone marrow transplants.

Private clinics are the main health provider for private-sector expatriates as they are not allowed to use the medical services funded by the Saudi Ministry of Health (henceforth referred to as MOH), except for emergency purposes. Many Saudis also prefer to pay for private healthcare because the waiting time in the private clinics is much shorter than that in the governmental hospitals. Moreover, some companies provide private health insurance to their staff who are thus eligible to use private health services.

In the following section, an overview of the governmental clinics and associated activities is provided.

#### **3.4.1.2. Governmental hospital (H3)**

The governmental hospital (H3) serves a wide geographical area of the western region, including urban and rural locations. It provides comprehensive medical and nursing care to cancer patients. In addition, the Oncology Centre provides

complementary services in paediatric oncology, surgical oncology, chemotherapy, radiotherapy, and blood transfusions and the transfusion of blood products. Those who receive healthcare services from the Oncology Centre in this hospital are: (a) Saudi patients, (b) patients referred through the Royal Cabinet<sup>27</sup>, (c) hospital employees and their dependants, and (d) non-Saudis working in Saudi governmental institutions. Terminally ill patients that would not benefit from chemotherapy, radiotherapy, and surgery or hormonal treatments are not accepted in this hospital.

The study focuses on governmental practice for several reasons. First, as previously noted, based on my fieldwork, it was usual where ample data was collected for the subsequent analyses, as many more Saudi female patients were accompanied by chaperones compared to the private hospital, that most attended appointments alone<sup>28</sup>. Second, the time I spent in the centre (two months) enabled me to understand the practices of the medical clinics in a governmental institution, as well as to appreciate the constraints and challenges the staff members face in these clinics.

Most of the patients (children, as well as female and male adults) coming to the Oncology Centre are either diagnosed with cancer<sup>29</sup> or referred by other primary care practitioners or hospitals as there is a suspicion they may have cancer. It was observed that some of the non-Saudi patients are treated either because they have received a Royal Order<sup>30</sup> for their treatment or they work in other public sector institutions. Others were paying for the treatment themselves. During the fieldwork, it was also noticed that the majority of the Saudi patients reside all over Saudi

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<sup>27</sup> For more clarification of this term, see the next section about the medical visit in Saudi Arabia.

<sup>28</sup> As a female nurse is available in the clinic, there is no need for a chaperone's presence.

<sup>29</sup> It was observed that some of the female patients have full knowledge of their illness, while some are only given partial information. However, some do not know that they have been diagnosed with cancer or they have reached fourth stage cancer (see Chapter Seven), whereby their chances of survival are significantly reduced (see the problems faced in fieldwork in this chapter in 3.6).

<sup>30</sup> The non-Saudi patients might be treated inside the kingdom only if they suffer from chronic illness. To receive free of charge treatment, non-Saudi patients would have to send an urgent letter to the Royal Cabinet office in Riyadh, explaining their health problem (or their relative's problem, if writing on his/her behalf), and provide all available supporting documents. The Cabinet, which is headed by the king and 20 members, 6 of whom are ministers, investigates the sender's problem. If they approve the request, a Royal Order (financed by the country) letter would be sent to the sender, informing him/her that the case has been approved and that he/she is eligible for free treatment inside the kingdom.

Arabia<sup>31</sup> and are accompanied to the clinic by male chaperones to receive treatment from the Oncology Centre. Around 67% of the patients included in this study came from outside Jeddah in order to be treated in this hospital.<sup>32</sup> The majority were attending a follow-up visit (94), whereas few (8) came for the first time. The data sample from this hospital included 94 patients who had previously visited the Oncology Centre and only 8 patients who had been referred for the first time to the centre by a primary care practitioner or a hospital consultant. On the basis of these observations, I was able to understand how a typical visit works in the Oncology Centre. Therefore, a detailed description of a typical Saudi medical visit, particularly in the context of H3, and the activities that took place in the consultation room, are provided below.

#### **3.4.1.2.1. Typical medical visit at the governmental hospital**

Upon entering the Oncology Centre, the patient (along with her male or female chaperone)<sup>33</sup> reports to the receptionist at the nurse station, which is located in front of the clinic offices. Sometimes, the male or female chaperone asks his/her sick relative to wait in the female waiting area until he/she reports their arrival to the clinic receptionist. As the receptionist's desk is not equipped with a computer, a paper-based outpatient appointment list<sup>34</sup> is maintained, in which the information regarding the clinic name, the doctor's name, the day and date of the appointment, patient's file number, the patient's name, the patient's identity number, age, and the file location all are included (see Appendix 5). Once the patient's attendance is

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<sup>31</sup> Most of the female patients depend on their male chaperones to transport to their medical appointments, as Saudi women are not allowed to drive.

<sup>32</sup> In the observation sheet, there is a question asking the patient whether or not they live in Jeddah (see Appendix 6).

<sup>33</sup> It was noticed that three male chaperones preferred not to enter the Oncology Centre and stayed in their cars in the car parks until the patients telephoned them and informed them that their appointment was about to commence. I had a chance to ask one male chaperone why he preferred to wait outside, to which he responded, "Between you and me, the name of this centre is frightening for me, not to mention the cancer patients themselves. I feel deeply upset when I see cancer patients, especially children, suffering from such dreadful and mortal illness."

<sup>34</sup> Outpatient lists made the data collection process much easier, compared to electronic ones. In the two private hospitals, where computers were used for this purpose, the receptionist had to use a password to access the database and tell me whether any patients had registered their attendance. Sometimes, the receptionist was not available, which made the data collection harder.

reported, the receptionist asks the patient and her chaperone to wait in the waiting area until her name is called by the clinic nurse.

Two waiting areas are provided, in order to segregate genders. Thus, if the patient is accompanied by a female chaperone, they both wait in the female waiting area, otherwise, the male chaperone has to wait separately from the patient. The female waiting area is closed off from public view while the male waiting area is open (as shown in Picture 1 below). It is entered through a glass door and provides three connected rows of seats placed against each of the walls. Some patients, as well as their female chaperones, uncover their faces in the female waiting area while others prefer to conceal their identity.<sup>35</sup>

**Picture 1.** Photo of the female and male waiting areas and the spacious area provided for both genders

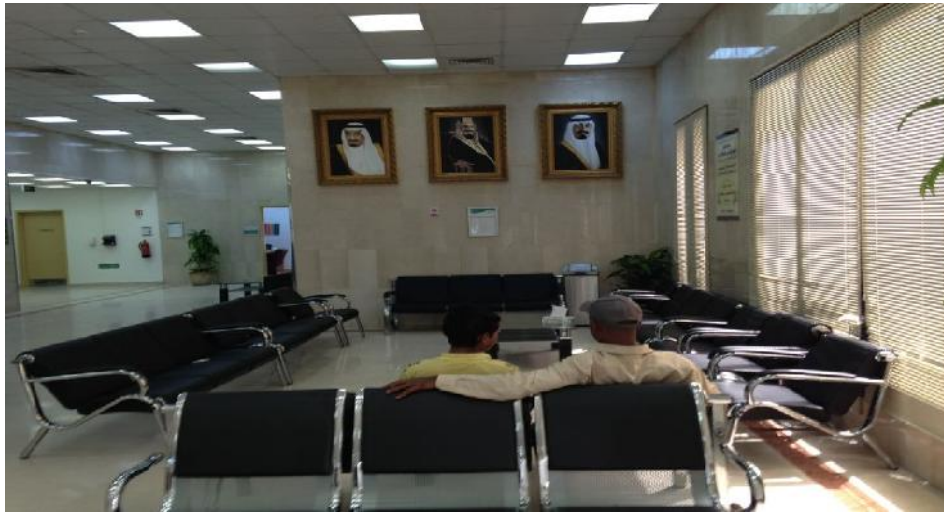


The male waiting area (see picture 1) is a small open area facing the nurse station and the clinics in the corridor. A row of four connected seats is placed behind each other and a flat-screen TV is hanging on the wall for the male patients and their male chaperones to watch while waiting for the appointment. There is also a spacious area in front of the hospital entrance, with three rows of connected seats, provided for patients and their chaperones that prefer to sit together, rather than using the female and male waiting area (see Picture 2).

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<sup>35</sup> Men are not allowed to enter the female waiting area. If a male chaperone wants to contact his sick relative, he either phones her, or knocks on the glass door calling his name, instead of hers. He might also refer to her as Umm (mother of), followed by the name of her first son, as uttering a female name in the public especially in front of men would bring shame (Buchele, 2008).

**Picture 2.** Photo of the spacious area where both genders can sit in H3



When the patient's name is called, the nurse takes the patient to a small room to take her blood pressure, temperature, and weight. The nurse notes this information and attaches it to the patient's file, before asking the patient and her chaperone to wait again until the patient's name is called by a phlebotomist. When a phlebotomist calls the patient's name, she takes her to a small room close to the blood laboratory, where she takes a blood sample to assess the patient's general health or to test how certain organs (such as the liver and kidneys) are functioning.<sup>36</sup> The blood test results are subsequently sent to another nurse, who attaches them to the patient's file. The phlebotomist then asks the patient and her chaperone to go back to the waiting area until her name is called. The waiting time to see the doctor depended on the number of patients that had previous appointments and can range from a couple of minutes to an hour.

After some time, the assistant nurse comes to the female waiting area, calling the patient's name<sup>37</sup>. If the patient has a female chaperone, they go together to the doctor's clinic. If the patient's chaperone is male, she finds him standing and waiting for her to go to the clinic together. Otherwise, if the patient attends the

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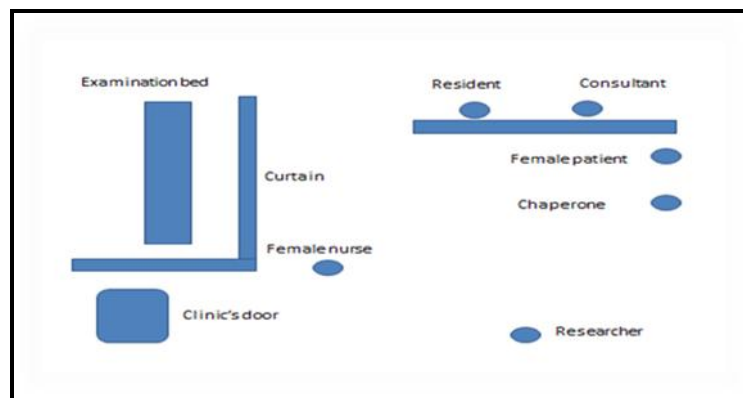
<sup>36</sup> This depends on the reason for taking the blood sample.

<sup>37</sup> It is acceptable to call the patient's name –(by healthcare personnel) for medical purposes.

appointment alone, a female nurse is always available in the clinic.<sup>38</sup> The consultation begins by either the patient or her chaperone greeting the doctor, who reciprocates and asks them to take a seat.

The patient sits on the chair in front of the consultant's desk, while her chaperone either sits next to her or in front of her (see Picture 3). A female nurse is also available, in case the doctor wants to examine the patient. It was observed that there are two physicians or more in the consultation room in addition to the consultant (i.e. a specialist, a resident, and a medical student). To begin discussing the patient's case, the specialist or the resident doctor turns his face towards the consultant to dictate to him the patient's file number, which is located on the computer. It was observed that most of the time, in the oncology clinics, the consultant would discuss the patient's case with the specialist or resident (sometimes the clinic is run by three doctors: a consultant, a specialist, and a resident) and their interaction is conducted entirely in English.<sup>39</sup>

**Picture 3.** Seating arrangement in a typical three-party medical interaction



The communication pertaining to the medical case is directed either to the patient or to her chaperone. It was observed that if the patient has a good knowledge of her illness, she usually answers the doctor's questions and her chaperone aligns with her either to confirm what the patient says or provides more information about

<sup>38</sup> The presence of a nurse in a governmental hospital is important for the Ministry of Health Legislation (see Chapter 1, (1.4.2.2.)), which mandates that a female patient should never stay with a male doctor alone, or be subjected to physical examination without a female nurse or a chaperone present.

<sup>39</sup> The consultant and resident speak Arabic with the patient and her chaperone, as English is reserved for the communication among the attendant oncologists only.



the patient's symptoms. In exceptional cases in which the patient has no knowledge about her illness, it is her chaperone who engages in the discussion of the patient's problem. Sometimes, the patient is accompanied by two or more chaperones. In such cases, one of the chaperones, usually male, is more dominant.

After discussing the patient's case with the oncologist, the consultant asks the patient an opening question about her health and how she has been taking the medication or other forms of treatment.<sup>40</sup> He also discusses the results of the tests she has already completed and compares them with the previous results by looking at the notes in the patient's file. If the patient wishes to discuss a new problem (especially, if this is her first visit) with the consultant, the doctor would presumably conduct a physical examination. If the patient refuses to be examined by a male doctor, a female doctor is called to conduct the examination on his behalf. If the female doctor is not available, the patient usually accepts being examined by the male doctor with her face fully covered. After the examination, the doctor gives the diagnosis and discusses the treatment procedure. At this time, he also prescribes any medication that should be taken and obtained from the pharmacy. However, in some cases, if the patient comes for a chemotherapy dose, she will be admitted immediately after the consultation. Sometimes, the consultant asks for further tests or an x-ray to be performed after the consultation is finished and schedules a follow-up appointment in 4 to 6 months' time. If this is the case, the nurse gives the patient an appointment sheet for the patient's next appointment and asks her or her chaperone to register her appointment in the Outpatient Appointment Department. Finally, the doctor closes the consultation formally, by addressing both the patient and her chaperone, who reciprocate, either by giving advice regarding the patient's health, or reminding them about the next appointment and the blood test required, or by asking if she or her chaperone has questions to ask. If any additional tests are required, these are conducted before the patient and her chaperone leave the hospital or are planned to be conducted in the town where they come from (and then they will bring the results of the tests to their next appointment). In some cases, the doctor sees the patient and her chaperone for a second time on the same day, mostly in the

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<sup>40</sup> If the patient attends the clinic for the first time, the doctor asks her to describe her complaint.

afternoon, to discuss the results of the blood test and the x-ray. The length of the appointment varies between 2 and 30 minutes.

More information about the participants who took part in the study, the entire study sample (the participating patients, their chaperones, doctors, and nurses) recruited from the three hospitals is discussed below.

### **3.4.2. Participants**

A convenience sampling approach was chosen for the identification of the study participants, who were included in the study because of their convenient availability (Gray, 2009). In other words, the study sample consisted of all individuals who attended the 20 outpatient clinics at the three hospitals in Jeddah from November 2011 to January 2012. The study sample also included (a) patients and their chaperones; (b) clinicians; and (c) nurses. Each participant group is discussed below.

Eligible patients and their chaperones were selected for inclusion in the study if they met the following criteria: (a) the patients were accompanied and had an appointment in the outpatient clinics (in one of the three participating hospitals); (b) both patients and their chaperones were aged 19-75 years; (c) both patients and their chaperones agreed to have the consultations recorded, as well as agreeing to complete a patient satisfaction questionnaire <sup>41</sup>; (d) both were cognitively competent and were able to communicate in Arabic during the three-party interaction.

Patients (and their chaperones, if applicable) were ineligible if (a) they were non-Saudi (N = 89 [H1 = 45; H2 = 34; and H3 = 10]); (b) patients came to the appointment alone (N = 87 [H1 = 30; H2 = 33; and H3 = 24]); (c) if the nurses or patient/chaperone indicated that the patient had some cognitive impairment 2 (N = 2 [H3]); and (d) if either the patient or the chaperone refused to participate.

Based on the above criteria, 117 patients were recruited from the three hospitals to take part in the study (see Table 1 below). More specifically, 13 patients attended H1, while two were recruited from H2, and 102 from H3. In addition, 48

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<sup>41</sup> In my observations, some patients and their chaperones had different views: if the patient agreed to participate, her chaperone refused for different reasons (audio recording, sickness, waiting for the results) and vice versa. If the chaperone agreed, her sick relative refused for the same reasons (see problems faced during data collection in 3. 6 in this chapter).

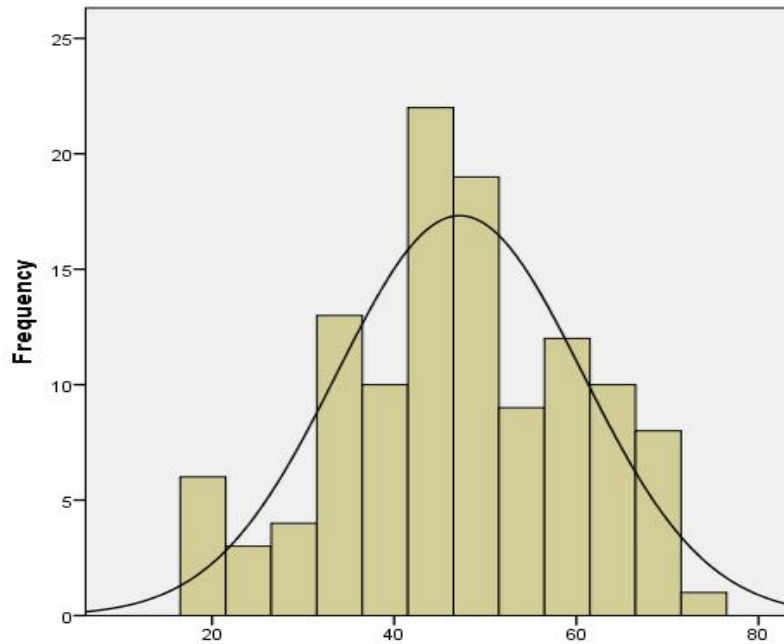
patients from the three hospitals (10 from H1, 3 from H2, and 35 from H3) *refused* to participate for different reasons: 20 patients did not wish to be audio-recorded, 13 declined because of being tired and sick, 9 refused to participate because of travelling from a distant town or village, 4 were worried about the blood test results, 1 because of invasion of privacy and 1 could not take part because of having an exam the next day.

**Table 1:** Demographic data of the participants (patients & their chaperones) who participated in the study from three hospitals in Jeddah (KSA)

Patient's age range	Patient's education	Chaperone gender				Total (N=117)
		Male (N=58)	Female (N=47)	Male & Female (N=10)	Group (N= 2)	
40-75	Did not attend school	18	26	6	1	51
38-68	Elementary school	13	6	1	-	20
22-58	Intermediate	8	6	-	1	15
19-50	High school	8	5	2	-	15
24-32	Diploma	2	-	-	-	2
19-51	University	8	4	1	-	13
44 (N=1)	Post graduate	1	-	-	-	1

Concerning the patients' age, the average (mean) patient age was 47.2 years with a standard deviation of 13.5 years. The median age was 47 years, while the youngest patient was only 19 years old, and the oldest was 75 years old. The distribution of patients' ages is not significantly different from a normal distribution, following the familiar bell-shaped curve (Figure 4).

**Figure 4:** Normal distribution of patients' age



In terms of the patients' education status, of the 117 patients that took part in the study, 51 (43.6%) did not attend school, 20 (17.1%) attended elementary school, 15 (12.8%) attended intermediate school, 15 (12.8%) attended secondary school, just 2 (1.7%) had a diploma, 13 (11.1%) attended university, and just 1 (0.9%) had a postgraduate qualification. As there were only two patients with a diploma and one with a postgraduate qualification, these were combined with those that had a university degree, and this group is henceforth referred to as further/higher education.

With regards to patients' age range for each patient's education level, as seen in Table 1 above, the patients' age range from 19 to 75 years old as follows: patients

from 40 to 75 years did not attend school. Patients with age range from 38-68 attended elementary schools, 22 to 58 years old patients had intermediate certificate, 19-50 years old patients had intermediate school. 19-50 attended high school whereas 24-32 years old patients had university learning. The age range of the patients who had diploma was from 19 to 51 years old. The patient with a postgraduate certificate was 44 year old.

Regarding the chaperone's gender, as seen in Table 1 above, of the 117 patients who (100%) mentioned the gender of their chaperone, 58 (50%) had a male chaperone, 47 (40.5%) had a female chaperone, 10 (8.6%) had both male and female chaperones, and 2 (1.7%) chose "group" as a response to this question.

To find out the correlation between the patients' education and the chaperones' gender, it was observed, in Table 1 above, that the number of male chaperones accompanying female patients is more than those of their female counterparts. Moreover, patients with male chaperones overall have higher education levels than patients with female chaperones.

Before discussing doctors' and nurses' participation, it is important to mention certain remarks or observations about the collected data. The data is unbalanced in various ways; first, there is an unequal distribution in the collected chaperones' genders who accompanied the female patients. The number of male chaperones was higher in comparison to that of female chaperones (male n= 58, female n=47). Second, patients who were accompanied by male chaperones have a higher level of education in general than that of their female counterparts. Third, patients' ages differ with respect to their education. The unequal distribution of subjects' numbers by chaperone gender, and patient's levels of education may affect the statistical findings as will be seen in Chapter 4.

To prepare the data for the statistical analysis, as shown in Table 1 above, there were only two patients with a diploma and one with a postgraduate qualification, and these were combined with those that had a university degree. This group is henceforth referred to as further/higher education. Again, to make further analysis easier, the patients that were accompanied by a group of chaperones were combined with those having both male and female chaperones.

In terms of the doctors' participation<sup>42</sup>, 32 male and 1 female doctor, from three practices, took part in the study (H1 = 9, H2 = 2, and H3 = 21 + 1 female doctor). Based on the observations of the daily procedures at the clinics in the public hospital, each physician typically sees 2-4 patients for whom it is the first visit and 20-30 patients that are attending a follow-up visit.

Regarding the nurses' participation, 18 assistant nurses from the three hospitals took part in the study, of whom 2 were from H1, 2 from H2, and 14 from H3. It was observed that the nurses were responsible for preparing the medical files of each patient, organising the patients' attendance at the appointment, the number of chaperones they had<sup>43</sup>, accompanying the patients and their chaperones to the clinic, monitoring the patients' condition by taking the patients' temperature, pulse, weight, height, and blood pressure, assisting the doctors with the physical examination, giving the follow-up sheet to either the patients or their chaperones, and providing necessary explanations, i.e. non-medical (such as, the location of the pharmacy or the x-ray room). Although they rarely participated in the medical consultation, they were involved in the social conversation that took place when the patients greeted them, or when the nurses welcomed the patients and asked them about their health<sup>44</sup>, (such as how are you mama?<sup>45</sup> or how is your health?).

Collecting and analysing the medical data was governed by ethical issues that had to be followed. In the following section, ethical consideration for data collection and data analysis is discussed.

### **3.5. Ethical Consideration**

Potential ethical issues were carefully considered before and during the research period. Before the research process, this research was approved by the ethics committee of the Linguistics and English Language Department of the

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<sup>42</sup> There was no need to obtain consent from the physicians and nurses to participate in the study as the head of the Research Centre informed me (in light of the meeting held between the head of the Research Centre and the physicians) the names of the physicians who were willing to participate and those who were not. In spite of this, I had to meet each physician in person to confirm that they may/may not be willing to participate.

<sup>43</sup> On one occasion, when four chaperones entered with their vulnerable relative, the nurse asked that at least one leave the consultation room, as there was not enough space.

<sup>44</sup> I noticed that some of the cancer patients who have been visiting the public hospital regularly knew the nurses very well and vice versa.

<sup>45</sup> As a way of showing respect to elderly ladies, we usually refer to them as "mama," to place them in our mothers' rank.

University of Edinburgh. The study was also approved by the Committee of Medical Research Ethics in three hospitals in Jeddah, Saudi Arabia. This study was conducted according to the Ethical Guidelines of the British Association of Applied linguistics (henceforth BAAL) (2010), and the codes of the Saudi National Committee on Bio and Medical Ethics in gaining access to participants (National Committee on Bio and Medical Ethics).

During data collection, I had to obtain consent from the female patient and her chaperone either in the female waiting area, male waiting area, or in an open waiting area where the patient and her chaperone sat together (see Appendix 7 for a copy of a consent form for patients and their chaperones). If the patient was accompanied by a female chaperone, they usually waited in the female waiting area. In this situation, it was easy for me to approach the participants and seek their consent to take part in this project. However, if the patient was accompanied by a male chaperone, the situation follows two directions. I had to meet the female patient in the female waiting area and ask her consent. Then, I followed the same process with her male chaperone. Sometimes, the patient phoned her male chaperone to meet all together to explain the project and the methods of data collection. If they both agreed to participate in this study, they signed a consent form on which they printed their names and each of them signed next to his/her name and provided their emails for sending the dissemination of the research findings. The date of filling in the consent form was also given.

Signing the consent form was an important issue I faced during the data process. If the patient was illiterate and her chaperone was educated, I had to read the consent form for the patient aloud to ensure that she understood everything. If she agreed to participate, either she signed by using a thumb stamp<sup>46</sup> or her chaperone signed on her behalf. A third party was involved as a witness if both the patient and her chaperone were illiterate<sup>47</sup>. During the data process, seven female patients along with their chaperones were illiterate. According to Saudi Biomedical Research Ethics, oral approval should be taken from illiterate participants after a full

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<sup>46</sup> I had to bring a thumb stamp myself or use the one in the Research Centre in the hospital.

<sup>47</sup> One of the codes of the Saudi National Committee on Bio and Medical Ethics is to have a third party in attendance if both participants are illiterate. A third party can be (a patient or a chaperone of other patients) found in the female or in the male waiting area.



explanation of the project with the presence of two witnesses. The illiterate subjects signed by using a thumb stamp next to each of their names and underneath the names and signatures of the two witnesses were also included on the consent form.

The written information on the consent form included: the researcher's name and her university, the aims of the project, the sponsor of this study, the approval received from the Ethics Committee from the hospital where the patient<sup>48</sup> is seeking treatment, and the methods of data collection. Ethical issues concerning patients' confidentiality and their decisions to participate were fully highlighted and respected on the consent form. Therefore, I have replaced participants' names in all transcripts with invented ones and deleted any information such as the name and the location of their hospitals which might reveal the patients' identity. I assured the participants that the collected data would be used for research purposes only, and just the researcher along with the examiners would have access to the audio recordings, which would be destroyed soon after the PhD thesis had been successfully presented or marked. In addition, I assured the patients that their responses would be treated with complete confidentiality, and would be linked to the recordings by a code to preserve anonymity. I also emphasised that their decision to participate or not would not affect their rights in any way and would not affect their treatment. I also explained that they could withdraw from the study at any time without any negative consequences. The consent form ended by listing the researcher's email and the contact number of the research centre of the patient's hospital.

It is important to note here that following the codes of the Saudi National Committee on Bio and Medical Ethics Biomedical Research, I gave a copy of the consent form to the patients in case they wanted to contact the researcher or the Research Centre at the hospital regarding their participation. A second copy of the signed consent form was also inserted into the patient's medical file and the original copy was saved by the researcher in case the Research Ethics office needed it<sup>49</sup>.

On collecting the mixed-methods data for the current study, I faced a number of obstacles that I will mention in the following section.

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<sup>48</sup> Some patients in preliminary observation asked me whether or not the hospital knew this research and data collection process was taking place.

<sup>49</sup> The governmental hospital asked for the patients' consent forms daily to save them in the research file.

### **3.6. Problems Encountered During Data Collection Process**

This section concentrates on some particular issues encountered in the data collection phase and the tactics used in dealing with them. It also included my failure to resolve issues with some painful cases that came up in the research process.

One of the biggest problems I encountered at the beginning of the data collection was the number of Saudi female patients coming to their appointments with their chaperones to the two private hospitals. My three months fieldwork plan was to collect a total of eighty cases, 40 male chaperones and 40 female chaperones. In three weeks, I was able to collect 13 cases only from hospital 1 and two cases from hospital 2. I was advised to contact a specific governmental hospital as soon as possible as the number of Saudi patients there was twice the number of the private hospitals. Within one week, I received an official letter to start collecting the data process in the governmental hospital. Therefore, I was obliged to send my apology to the two private hospitals for the above-mentioned reason and send a full fieldwork report including the problems that arose during the fieldwork phase. Afterwards, I started collecting data from the NHS hospital, and one hundred and two cases were successfully collected within two months.

The second problem was having two patients from two different clinics at the same time. The Saudi nurses were always behind me when I faced such complicated cases. The Saudi nurses who were serving both clinics and dealing with both patients successfully solved this problem. One nurse explained the matter to the potential patient and asked her permission to let another patient enter before her in order for me to finish with the first patient and attend the consultation with her. From this, I had to inform the nurses who worked for the different clinics of the patients who had given me consent in order to organise my observation and time with each one of them. Sometimes, I had a regular meeting with the nurses during lunch time to put forward different solutions to any problem that might be happening during data collection. For example, how to approach the Saudi female patients and how to organise attending different consultations at the same day. This approach was conducted until the end of my fieldwork which resulted in well-organised data from different clinics in H3.

The third problem was the disappearance of the patient's male chaperone during the data collection after his consent was gained. For example, when the patient's name was called, I accompanied the patient to the doctor's clinic and I discovered that her chaperone had all of a sudden disappeared. For this reason, I was not able to record the consultation. When this problem occurred three times, I had to inform the patients' male chaperones to be available and if they wanted to go somewhere else, they had to either inform me, the nurse station or even their sick relatives. Such a problem was successfully resolved but sometimes was beyond my ability.

The fourth problem was the failure to obtain a recording from participants. Audio-recordings were not an acceptable device to some doctors, so some of them did not participate in the study. A few doctors asked me whether the purpose of audio recording was to evaluate their behaviour with their patients along with their chaperones. Likewise, some patients and chaperones said they felt uncomfortable with the idea of being audio-recorded. In contradicting situations the patients gave me consent to record the consultation, but their chaperones completely disagreed with them and vice versa. In both cases, I had to respect their opinions and not to force them to participate in the study according to research ethics.

The fifth and the most painful experience I have ever faced in my life particularly in a medical setting was concealment of the truth. In exceptional cases, some cancer patients do not have full knowledge about their illness, whereas others had partial knowledge. The most critical point was that when I asked for consent from the patient and completed the information sheet with her, she reported various symptoms of her illness. However, her chaperone disclosed in a whisper that the patient had been diagnosed with cancer but she did not know anything. I was repeatedly warned not to tell the patient the reality of her illness. In addition, I was also advised to be very careful when filling the questionnaire with the patient. In another clinic, I was present when a critical case from a surgical oncology clinic discovered the truth about her illness, i.e. cervical cancer in the fourth stage, where the cancer had spread from the cervix to the bladder and rectum. However, her husband had told her that she had a benign tumour, which had been removed,

whereas in reality it was a malignant tumour (See Chapter Seven of epistemic asymmetry).

Not only did some patients not know their real illness but their chaperones also did not even know that their relatives had cancer. For instance, a young cancer patient who had full knowledge of her illness, whereas her brother, who accompanied her knew nothing. Unintentionally, I was involved in truth concealment. When taking the patient to the doctor's office, I was also told to report to the oncologist the chaperone's desire that the patient knew nothing about her illness<sup>50</sup>, so he had to be very careful when talking with the patient. In both these cases, I was warned not to disclose the reality of the illness neither to the chaperone nor the patient.

In two different clinics, evidence of truth concealment had been recorded inside the consultation room. In a chemotherapy clinic, a liver cancer patient was asked to wait in the female waiting area in order for her husband to discuss her drugs with her doctor. In fact, the patient had reached the fourth stage cancer where there is no effective solution to stop the tumour from spreading to other organs of the body. In a crying voice, the patient's husband was asking whether or not to take the patient abroad to do an operation and save his wife's life. The doctor's response was out of his hands as the patient had reached the end of life stage. The husband was advised by the doctor to hide the truth for the sake of the patient's psychological state.

Non-disclosure of cancer diagnosis was also documented in a haematology clinic. A leukaemia patient was accompanied by her son and daughter. When asked for a physical examination, the roles were divided. The patient's daughter went with her mother to the examination bed while her son took the opportunity to ask the oncologist about his mother's health condition. In a very low voice, the patient's son said that his mother had been diagnosed with leukaemia two years ago and she had no background knowledge about her illness.

In spite of the above-mentioned problems that stemmed from field research, these problems did not reflect on the methods. Therefore, I was able to collect 117

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<sup>50</sup> The chaperone noticed that the doctor who will see her mother is not her mother's usual doctor.

cases from three hospitals in Saudi Arabia hoping to find solutions for the painful cases encountered in the fieldwork.

In collecting and analysing naturalistic data from fieldwork, there are certain criteria that should be taken into consideration to ensure the quality and the trustworthiness of qualitative research (Karout, et al., 2013). These criteria are discussed in the following section based on the suggestions made by Lincoln and Guba (1985).

### **3.7. Trustworthiness of Qualitative Data**

In this project, four measures were addressed to establish the trustworthiness of the qualitative data, with the goal of presenting a convincing as well as a true picture of the three-party interactions during a medical visit in Saudi Arabia. The four measures of trustworthiness in qualitative research—namely, credibility, transferability, dependability, and conformability—were thus taken into account (Lincoln & Guba, 1985). Each of these elements of trustworthiness is discussed below.

Credibility is considered as one of the most important elements in pursuing trustworthiness (Lincoln & Guba, 1985). It refers to the assessment of the study findings in order to establish whether the description of the data represents a true and credible picture of the participants' original data (Lincoln & Guba, 1985). To ensure credibility, four provisions were employed, namely "prolonged engagement" (Lincoln & Guba, 1985, p. 231), along with triangulation methods of data collection and data analysis, participants' honesty, and peer scrutiny of the data analysis (Shenton, 2004). Each one is explained below.

Lincoln and Guba (1985) argued that, in order to achieve credibility of qualitative data, "prolonged engagement" (p.231) with participants (and their organisation, if applicable) is needed. In accordance with this view, as a part of this study, before the actual data collection took place, the researcher made preliminary visits to the two private hospitals for one week. In spite of being short, these visits provided valuable experience. The researcher was present during two shifts, from 9 am until 1 pm, and from 5 pm until 9 pm. The main goal of these visits was to gain familiarity with three important aspects of the medical setting: (1) the structural

organisation of the hospitals, (2) the medical visit, and (3) the most unobtrusive place to sit in the consultation room. The preliminary visits also helped in gaining a better understanding of the organisation.

The credibility of this study is also maximised by the triangulation of several data sources. For example, thematic analysis of the responses given to the qualitative open-ended questionnaire was used in order to develop an in-depth understanding of the Saudi female patients' perceptions of their chaperones roles during their medical visits and any variation in the role characteristics that are related to the chaperone's gender. A qualitative observation with a conversation analysis framework was used to describe the emergence of alignment as well as to investigate epistemic asymmetry during three-party interactions. The real-life observation was also used to check any incongruence between observations of the medical interaction and what the patients reported about the role of their chaperones and any gender differences in the caring role during the medical visit. This diversity of sources provides a multitude of perspectives and attitudes, which contributes to a rich and more stable picture of reality "based on observation from a wide base of points in time-space" (Dervin, 1983, p.5). The female patients' views of their chaperones are presented in their own words so that their voices may be heard, as well as to enable readers to assess their credibility (Shenton, 2004).

The credibility of this study was further increased by taking steps to help ensure the participants' frankness and honesty when contributing data (Shenton, 2004). Ethical considerations were respected and applied in this study when approaching the participants. Only those physicians, nurses, patients and chaperones who confirmed their willingness to take part in the study were observed and questioned. One of the reasons behind specifically targeting the Saudi patients in this work was based on previous research indicating that Saudi patients would share perceptions with a Saudi researcher more frankly than with researchers belonging to a different ethnic group (Miller & Glassner, 2004; Rew et al., 1993). Therefore, Saudi patients were encouraged to be honest and frank from the beginning of the data gathering. They were also urged to behave naturally<sup>51</sup>, regardless of the Saudi female researcher's presence in the consultation room. Patients were also assured and

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<sup>51</sup> Some physicians asked me how to behave during the audio-recording sessions.

promised that their responses about their chaperones' attitudes would not be seen by their physicians or the chaperones.

Credibility was also ascertained by conducting peer scrutiny of the data analysis in different academic sites, where feedback was offered by academics, colleagues and peers. For example, working together with SEDIT<sup>52</sup> at Edinburgh University, presenting parts of this work at postgraduate and at international conferences (Al-ayyash, 2012), as well as attending three-day long training workshops with experienced discourse and conversation analysts from all over the world at Cardiff University (2012) and Loughborough University (2013) enhanced the credibility and trustworthiness of this project. In these data analysis sessions, the audio-recorded medical transcripts were analysed and the feedback obtained yielded invaluable and in-depth information, as well as helping to understand the audio-recorded data through other researchers' perspectives (see Chapter Six for analysing the audio-recorded data).

The second measure of trustworthiness is transferability. The findings of this project cannot be applied to a wider population from other cultures where the required presence of a male chaperone with a female patient does not apply. However, following the guidelines of qualitative research scholars (Miles & Huberman, 1994; Shenton, 2004), a detailed description of the phenomenon of the three-party interactions in Saudi Arabia was provided. Sufficient information about the data collection was given from the outset. Ethical considerations of this project were described. Problems encountered during the data collection process were documented, and a detailed description of the findings was given. This would allow the readers to compare the findings described in this research with those instances that they have seen emerge in their situations. Then, they would judge the applicability of the findings in other contexts.

To address the issues of the last two measures of trustworthiness, namely, dependability and conformability, as reported in observation and audio-recording (see 3.3.3), a Zoom H2 Handy Recorder was used and medical consultations were transcribed verbatim before being analysed (see Chapter Six). For illiterate patients

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<sup>52</sup> Scottish Ethnomethodology, Discourse, Interaction & Talk (Group), a community of researchers from different disciplines, gathered every fortnight at Psychology Building, George Square, Edinburgh University.

who could not fill in the questionnaire, the researcher acted as their assistant. In such cases, all questions were read aloud and similar questions were asked. In addition, the steps of thematic analysis and conversation analysis were described and followed for both the future researcher and the reader; the former was to duplicate the work, albeit unnecessarily, to obtain the same results, whereas the latter was to gain an in-depth understanding of the methods used and their effectiveness (Shenton, 2004). Member checks were used to check the accuracy of the English translation of the medical transcripts of the qualitative observation and open-ended questionnaire data. Two independent research colleagues who are familiar with thematic analysis were asked to independently code all the original transcripts of the open-ended questionnaire data. The researcher and the independent researchers subsequently discussed the similarities and differences among the emergent themes yielded by these separate processes. For additional scrutiny, the coded extracts of data and the emergent themes were discussed with the supervisors of this project for guidance.

In summary, by following the above measures that enhance the trustworthiness of qualitative research, it is hoped that the validity of this project was successfully achieved.

### **3.8. Summary**

In this chapter, I have described the convergent parallel mixed method design employed in the present study and aimed to get a better understanding of the phenomenon of three-party interactions in Saudi Arabia. I have discussed the procedure of data collection for the qualitative data (i.e. observation and audio-recording) first followed by quantitative data (i.e. questionnaire) leaving the description of the procedure of analysing each data in its analytical chapter. I have described the research setting, participants, and how a typical medical visit works in the governmental hospital in Saudi Arabia. I have presented ethical considerations. I have also discussed some practical problems encountered during the data collection process. I have included the four measures employed in this study to ensure trustworthiness of the qualitative data.

In the remainder of this thesis, I turn to the quantitative and qualitative analyses of the major issues pertaining to three-party interaction. In the following chapter, the



procedures of analysing the questionnaire data and the findings of the statistical analysis regarding patient satisfaction with three-party medical visits are discussed.

## CHAPTER 4

### Patient Satisfaction with Three-party Consultations

#### 4.1. Introduction

The aim of this chapter is to present the statistical findings of the first research question regarding the factors (i.e. the effect of patients' age, patients' level of education, and the chaperone's gender), that influence patient satisfaction with (1) overall care, (2) chaperone care, and (3) chaperone involvement. We are expecting to find a significant effect between the independent and dependent variables. Measuring patient satisfaction is the starting point in this study in order to look for the general features of patient satisfaction in three-party interactions and to uncover the factors that matter most to patients and lead to their satisfaction with the quality of care. Therefore, understanding the association between patients' or chaperones' socio-demographic characteristics and patient satisfaction may guide clinicians to understand the patients' needs (see Chapter 2). In this chapter, I first turn to thoroughly describing the design of the questionnaire employed for gathering data on patient satisfaction (section 4.2), followed by the methods employed in the data analyses (section 4.3). I finish by discussing the results of the statistical analyses of the questionnaire data in (section 4.4).

#### 4.2. Questionnaire Design

To answer the first research question in this thesis, i.e. What are the factors (if any), for example, patients' age, patients' education, and chaperone's gender, that affect patient satisfaction with (1) overall care, (2) chaperone care, and (3) chaperone involvement in three-party consultations?, a self-administered questionnaire was used to measure patient satisfaction in three-party interactions. The structured questionnaire (the English version is reproduced in Appendix 12 while the translated Arabic version is given in Appendix 12a) explored the patients' opinions and experiences regarding the medical visit and the role their chaperones play in the

doctor-patient consultation. The questionnaire was designed and developed in English, after a thorough review of the pertinent literature sources, which were identified using the following keywords: triad, companion, significant others, third person, caregiver, carer, family, relative, family involvement, patients' perspectives, medical consultation, accompanying person, medical encounter, and medical visit. The questionnaire was reviewed by my two supervisors, who provided comments and suggestions, resulting in minor changes to several items. The final version of the questionnaire, written in English, was subsequently translated into Arabic (see Appendix 12a). The translated questionnaire was checked by a Saudi friend in Edinburgh.

#### **4.2.1. Questionnaire Parts/Measures<sup>53</sup>**

The structured questionnaire included six sections, which covered six domains. These sections are explained below.

##### **4.2.1.1. Patient measures**

The first section asked about the patients' demographic information (e.g. the clinic they were attending, age, level of education, marital status, and type of visit). Patients had to indicate the type of clinic where they had their appointment, and their age, in the spaces provided. The level of education was categorised into eight groups (did not attend school, illiterate school<sup>54</sup>, elementary, intermediate, high school, diploma, university, and postgraduate), and the patient was required to select the one that corresponded to her educational attainment. Marital status was categorised into five groups (single, married, separated, divorced, and widowed), and the patient

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<sup>53</sup> The questionnaire included a covering letter attached to the front, introducing the researcher (i.e. providing my name, year of study, the name of my university and the department) describing the study, explaining what the patients were required to do, and the time commitment required. The logos of the study sponsor (i.e., King Abdulaziz University), as well as that of Edinburgh University, appeared on the letterhead as well as in the body of the covering letter. The hospital Research Centre was also mentioned because during the preliminary observation, a patient asked whether the hospital was informed of my research. Patients were assured that their responses would be treated with complete confidentiality, and would be linked to the recordings by a code to preserve anonymity. They were also informed that their answers would be used for academic purposes only and the questionnaire data would be destroyed after the research was completed (see ethical considerations in Chapter 3).

<sup>54</sup> A school for people who are illiterate, (i.e. unable to read and write).

selected the response that matched her present status. Type of visit was categorised into two types (e.g. first and follow-up).

#### **4.2.1.2. Chaperone measures**

The second section pertained to the patients' chaperone(s). It was divided into four sub-sections, with the first asking about the gender of the chaperone(s) who attended the consultation with the patient. The second sub-section asked about the chaperones' age and the third about their relationship to the patient. The fourth sub-section was about the chaperones' level of education, which was categorised into the same eight groups as above.

#### **4.2.1.3. Medical visit measures**

The third section of the survey questionnaire involved rating statements that examined to what extent patients were satisfied with the medical visit using a Likert-type scale. Therefore, the medical visit was rated using six scales to measure different aspects of satisfaction, each comprising one or more statements in which participants were asked to give a rating. In all but subscales 4 (i.e. rating the impact of the chaperone's involvement on doctor-patient interaction) and 5 (i.e. rating the effect of attending the consultation alone), the responses were given on a 5-point scale, where the patients had to select the answer that best corresponded to their level of satisfaction, choosing from: strongly agree = 5, agree = 4, uncertain = 3, disagree = 2, and strongly disagree = 1. However, the responses in subscales 4 and 5 were presented in reverse order.

The first scale rated the care provided by the physician. The first three items rated the physician's interpersonal skills. More specifically, the patients had to indicate their level of agreement with the following statements: (1) my doctor treated me with respect, (2) my doctor gave me enough time to describe my health problem, and (3) my doctor listened to what I was saying. The fourth rated the doctor's ability to obtain information, asking the patient to rate the statement (4) my doctor encouraged me to talk and ask questions.

The second scale rated the care provided by the chaperone. Patients were asked to rate the first two items regarding the chaperone's interpersonal skills, i.e. (1) my

chaperone treated me with respect, and (2) my chaperone gave me enough time to describe my health problem. The remaining two items rated the chaperone's ability to obtain and share information, i.e. (3) my chaperone encouraged me to talk and ask questions and (4) my chaperone clarified some information about me to my doctor.

The third scale rated the patient-chaperone relationship. Patients were asked to indicate whether they felt comfortable when they were talking to their doctors in front of their chaperones and whether they considered themselves and the chaperone as one person.

The fourth scale rated the negative impact of chaperone involvement on doctor-patient interaction. This scale measured three important effects: (1) doctor-chaperone alignment, (agreement with the statement "Sometimes, I felt that my doctor focused his attention on my chaperone rather than me"), (2) patient confidentiality (through the item "There were some issues that I would have liked to tell my doctor, but I could not"), and (3) the patients' marginalisation from the medical interaction ("Sometimes, I felt that I was excluded from the conversation").

The last two scales comprised of one item each. More specifically, the fifth scale assessed whether the patient would prefer to attend the consultation alone "If my circumstances permitted, I would have preferred to attend the medical consultation on my own"). On the other hand, the sixth scale assessed the chaperone's role inside the consultation room, ("My chaperone did not play a big part").

#### **4.2.1.4. Open-ended qualitative questions about the chaperone's behaviour**

The fourth section of the questionnaire included four open-ended questions that asked about patients' experiences of having their chaperone present during the consultation, as well as a space where they could add any additional comments, ensuring that no important issues were missed (O'Cathain & Thomas, 2004). In addition, a separate box was provided for the patients to write their own opinions and share views regarding their chaperones' behaviour. The questions included in this section were:

1. How would you rate your chaperone's behaviour during the consultation?
2. Overall, what (if anything) was GOOD about having your chaperone with you?

3. Overall, what (if anything) was NOT GOOD about having your chaperone with you?
4. If you have any additional comments regarding male or female chaperones, please write them below.

The responses of the above open-ended questions were subjected to qualitative thematic analysis as discussed in Chapter 5.

#### **4.2.1.5. Overall measures of the medical consultation and choosing the chaperone again for accompaniment**

The last section of the patient satisfaction questionnaire (henceforth PSQ) focused on an overall evaluation of the medical interaction and aimed to determine whether the patient would choose to involve the chaperone for the next medical appointment. The patients were asked two questions, to which they responded by ticking one answer (either yes, no, or not sure). The two questions were: (1) Overall, were you satisfied with the interaction between your doctor, your chaperone, and yourself? and, (2) Would you choose your chaperone again (if possible) if you had to have another medical consultation?

The rationale for using a binary category (yes, no, not sure) is related to the following: (1) patients might feel under pressure to say something negative about their chaperones; (2) patients might have no time to express their feelings towards their chaperones' attitudes during their medical visit; and (3) patients might find nothing to say about third-party medical interaction as they may be marginalised from the conversation and the discussion is mainly between their chaperones and physicians.

Having collected the questionnaire data, the first step that was taken into consideration was to prepare the data for the analysis. The techniques for this are described in the next section.

### **4.3. Data Analysis Techniques**

Prior to data analysis, two techniques for (1) checking the data and (2) checking the reliability of the questionnaire were employed (i.e. after the data was collected). Each is discussed in turn.

### **4.3.1. Checking the data**

After obtaining a sufficient number of completed questionnaires, data processing could commence. Data processing connects data analysis with data collection. Before starting the statistical analysis of the questionnaire data, different checking stages were implemented in order for any errors be identified and eliminated. The checking procedures include (1) cleaning the data, (2) coding the actual input of the data, (3) classifying the data, and (4) dealing with missing data. Each stage is discussed below.

#### **4.3.1.1. Cleaning the data set**

Three approaches were used to clean the data. First, the content of each questionnaire was entered into an SPSS (the Statistical Package for Social Sciences [version 21.0]) (IBM SPSS, 2012) file and all the entries were rechecked carefully. Next, frequency analysis was performed, whereby frequency, mean, and standard deviation were calculated. Finally, reverse-scoring of the Likert scale of the relevant items was carried out before conducting a reliability analysis. For example, the scoring of the three items in scale 4 and one item in scale 5 were reversed (e.g., from strongly agree = 5 to strongly disagree = 5) in order to improve the reliability (Field, 2012).

#### **4.3.1.2. Data coding and layout**

The coding of the questionnaire was performed by the researcher, whereby all the answers in the questionnaire were assigned a code number before a soft copy of the data was created. The data was coded using the SPSS v.21 software package. As the data was collected from 117 patients, in order to preserve their anonymity, each patient was given an ID number, which replaced her name in column 1 (e.g. P1). Each column in SPSS that presents a single variable was given a code number to signify a particular meaning (see Appendix 13, for data coding).

#### **4.3.1.3. Classifying the data**

It is important to note here that, during the coding process, data were classified into categories in order to ascertain the statistical tests that could be applied. Three types of the questionnaire data were classified as follows: ordinal (i.e., Level of

education, Overall satisfaction items, and Likert scale items), nominal (i.e. gender), and continuous (age). In the light of the classification scheme indicated above, statistical tests were carried out to answer the research questions of the study (see result section 4.4).

#### **4.3.1.4. Dealing with missing data**

Questions that were not answered, or resulted in ambiguous responses, were coded “-9999” and excluded from the analysis. In one case, the patient ticked by mistake two Likert scale ratings of the same item (i.e. strongly agree and agree). Ten questionnaires in which more than six data items were missing were excluded from the analysis. In such cases, -9999 was added to each empty cell.

The reasons for these incomplete questionnaires were: (1) the patients were probably tired, or (2) it was observed that the majority of patients travelled a long distance so there was no time for them to complete the questionnaire. Thus, of the 117 questionnaires, 108 (92.3%) were suitable for further statistical analysis.

#### **4.3.2. Reliability of the questionnaire**

A questionnaire is a measuring instrument that must initially be reliable (Field, 2012). This is ascertained by conducting a test that measures the internal consistency, i.e. establishes that a set of items comprising the scales within the questionnaire is equally and perfectly correlated (Field, 2012). Such a test is known as a reliability test and is measured using Cronbach’s Alpha. The Cronbach’s Alpha is acceptable, if it is in the range of between 0.7 and 0.8, as lower values indicate that the scale is not reliable (Field, 2012). The Alpha value highly depends on the number of items in the scales<sup>55</sup> and how a set of items are closely related to each other as a group.

On conducting the reliability test to see whether or not the items reliably reflect each scale, it was observed that none of the scales<sup>56</sup> in the questionnaire meet the criteria of 0.7 to 0.8. However, the two scales (2 [chaperone care] & 4 [chaperone

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<sup>55</sup> The questionnaire was devised to be short according to the recommendations of the previous patient satisfaction studies (Salisbury, et al., 2005; Thayaparan & Mahdi, 2013) for different reasons, one of which is that patients may be tired and they may not have time to complete the questionnaire. Statistical analyses were conducted on chaperone care and chaperone involvement scales as the alpha scores were quite reasonable.

<sup>56</sup> See the questionnaire in Appendix 12.



involvement]) are close enough to assume that some items in both scales show a positive correlation. However, in the remaining scales (1 [physician care], 3 [patient-chaperone relationship], 5 [attending the consultation alone], and 6 [rating chaperone's role in the consultation room]), the measure remains independent either because the items within the measure show no correlation or they are small.

The overall reliability of the scale (i.e., Alpha), mean, and standard deviation are presented in the results section while Cronbach's  $\alpha$  for each scale is given in Table 2.

The findings of the statistical analysis of the questionnaire data used in this study are presented in the following sections.

#### **4.4. Results**

To summarise again, the aim of this chapter is to present the statistical findings to the first research question in this study:

**What are the factors (if any) (e.g. patients' age, patients' education, and chaperone's gender) that affect patient satisfaction with (1) overall care, (2) chaperone care, and (3) chaperone involvement in three-party consultations?**

It is important to note that, in order to examine the effect of certain measures that have not been investigated in previous research, the following fields were selected: patients' age, patients' level of education, the chaperone's gender, and the overall area of medical consultation. In addition, two scales were selected: (1) rating the care provided by the chaperone, and (2) rating the impact of the chaperone's involvement on doctor-patient interaction. The scores of the two scales were calculated, and Alpha, mean (SD), and the correlation between scales are presented in Table 2 below.

**Table 2:** Alpha, mean, standard derivation, and correlation between two scales

Scales	Alpha	Mean & SD	Correlation between scales	
			Chaperone care	Impact of chaperone involvement
Chaperone care	.570	4.49 (0.68)	1.000	-.178
Chaperone involvement	.695	2.18 (1.23)	-.178	1.000

As can be seen in Table 2, the reliability of both scales could be better, as the overall for scale 2, measuring chaperone care is .570 while the alpha score for scale 4 (the effect of chaperone involvement on doctor-patient interaction) is .695. Both scales were chosen because the alpha values are quite reasonable compared to the lower scores of the remaining scales.

Therefore, the statistical findings are presented in three sections. First, the findings pertaining to the effect of patients' age, patients' level of education, and the chaperone's gender on patient overall satisfaction with three-party visits are provided. Next, the results related to the effect of the same variables on patient satisfaction with chaperone care and chaperone involvement are discussed separately.

The following section explores the relationship between the demographic variables discussed above and patients' overall satisfaction ratings.

#### **4.4.1. Effect of patients' age, education, and chaperone gender<sup>57</sup> on patient overall satisfaction)**

In this section, I first discuss the descriptive statistics of the dependent variable, i.e. overall patient satisfaction. Then, I present the descriptive findings concerning the effect of patients' age, education and chaperone gender on their overall satisfaction.

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<sup>57</sup> For the descriptive statistics of patients' age, education, and chaperone gender see Chapter 3 (3.4.2).

#### **4.4.1.1. Descriptive statistics of overall patient satisfaction**

When the patients were asked to indicate their overall level of satisfaction with the doctor and the chaperone, the results were as follows. Of the 117 patients, 107 (91.5%) provided answers to the question, while 10 (8.5%) did not. Of these 107 patients, 101 (94.4%) were satisfied with their doctors and chaperones, while 5 (4.7%) were not satisfied, and 1 (0.9%) was not sure. In further analysis, the one patient who was not sure of the answer was grouped with the five patients who were not satisfied, as having only two groups would make any inferences to the statistical analysis results easier.

The sections below present the descriptive findings on the effect of patients' age, education and the chaperone's gender on their overall satisfaction. Then, I focus on the six patients who were not satisfied with their doctors and chaperones, and present the qualitative findings of the effect of patients' age, education and the chaperone's gender on patient overall satisfaction with reference to those six patients who were not satisfied with the medical visit.

The rationale for conducting a descriptive statistical analysis other than statistical tests is due to two reasons: (1) failure to show any significance among patients' age, education and the chaperone's gender on patient overall satisfaction, and (2) failure to compare the unbalanced data, i.e. 101 satisfied patients versus 6 dissatisfied patients.

#### **4.4.1.2. Effect of patients' age, education and chaperone gender on overall patient satisfaction**

The average age of patients satisfied with their doctor and chaperone was 47.60, while the average age of patients that were not satisfied was 41.17.

With regards to patient education and patient overall satisfaction, it has been found that of the 101 satisfied patients, 45 (44.6%) did not attend school, 15 (14.9%) had an elementary education, 13 (12.9%) had an intermediate education, 14 (13.9%) had a secondary education, and 14 (13.9%) studied further or higher education. The corresponding number for patients who were not satisfied were 2 (33.3%), 2 (33.3%), 1 (16.7%), 0, and 1 (16.7%), respectively. A higher proportion of patients who did not attend school were satisfied compared to those who were not satisfied (44.6% vs.

33.3%). Among patients with an elementary education, a smaller percentage (14.9%) were satisfied, compared to 33.3% who were not satisfied, while 12.9% of those with an intermediate education were satisfied compared to 16.7% that were not satisfied. Finally, among patients who studied further or higher education, 13.9% were satisfied and 16.7% were not.

As far as the chaperone's gender is concerned, it was observed that of the 101 patients that were satisfied with the overall visit, 51 (50.5%) had a male chaperone, 41 (40.6%) were accompanied by a female, and 9 (8.9%) had both a male and a female present during the appointment. The corresponding values for patients who were not satisfied were 4 (66.7%), 2 (33.3%), and 0, respectively. A higher proportion of patients accompanied by a male chaperone were satisfied compared to those who were accompanied by a female chaperone (50.5% vs. 40.6%).

In summary, there does not seem to be any correlation between patients' age, education, and chaperone gender on patient overall satisfaction. Since none of the independent variables were significant, it is likely that any multivariate (regression) will not yield any significant effect/result. Indeed, the research performed a binary logistics regression and no significance was observed. Consequently, these variables have not been reported as they do not add any value to the research.

#### **4.4.1.3. Effect of patients' age, education and chaperone gender on overall patient satisfaction with reference to dissatisfied patients**

Regarding the effect of patients' age on patient satisfaction with reference to the six patients who were not satisfied with the visit, as shown in Table 3, the age range of patients who were satisfied with their medical consultations is from 32 to 50, i.e. young to old. Therefore, age does not affect patients' overall satisfaction.

**Table 3:** Association between patients’ age, education and chaperone gender on overall patient satisfaction with 6 patients dissatisfied with the consultation

<b>Patient no.</b>	<b>Age</b>	<b>Education</b>	<b>Chaperone’s gender</b>
P1	45	Did not attend school	Female
P5	41	Intermediate	Female
P31	32	University	Male
P87	35	Elementary	Male
P94	50	Elementary	Male
P100	44	Didn’t attend school	Male

Concerning the effect of patients’ education on overall satisfaction, Table 3 shows that of the six dissatisfied patients, two did not attend school, two had an elementary education, one had an intermediate education, and one studied higher education. This indicates that there is no relationship between patients’ educational status and their overall satisfaction.

As far as chaperone gender is concerned, as can be seen in Table 3 above, four dissatisfied patients were accompanied by a male chaperone compared to two who were accompanied by a female chaperone. Therefore, there is no relationship between the chaperone’s gender and patients’ overall satisfaction.

The following section presents the findings of the second part of the main research question (i.e. does patients’ age, patients’ education and the chaperone’s gender affect patient satisfaction, particularly in terms of chaperone care?).

#### **4.4.2. Patient satisfaction with chaperone care**

In order to answer the second part of the main research question, (i.e. do patients’ age, patients’ education, and the chaperone’s gender, affect patient satisfaction, particularly with chaperone care?), it is important to discuss the chaperone care scale first— with reference to the descriptive statistics (mean and standard derivation), and correlation between items.

Based on the mean and standard derivation pertaining to chaperone care (from 1-4 diagonally in Table 4 below); it is evident that the patients agreed with the statements, as the mean value was above 4. The standard deviations also indicate that the patients’ responses clustered around the mean for the first two statements, as all standard deviations were below 1. However, the responses the patients provided for

the last two statements were more varied. In spite of this, on average, it is fair to say that the patients rated highly the care provided by the chaperone.

Concerning correlation between items (see Table 4), it was observed that the highest correlation (0.528) was measured between the statements *My chaperone treated me with respect* and *My chaperone gave me enough time to describe my health problem*. This correlation is positive, fairly strong, and significant at the 1% level, indicating a linear relationship. However, this is not a cause relationship. The second highest correlation (0.387) was calculated between *My chaperone encouraged me to talk and ask questions* and *My chaperone clarified some information about me to my doctor*. This is also positive, moderate, and significant at the 1% level. The smallest correlation (0.226) was found between the statements *My chaperone treated me with respect* and *My chaperone encouraged me to talk and ask questions*. This correlation is positive, weak, and significant at the 5% level. The other correlations<sup>58</sup> ranged from weak to fair.

To examine the relationship between the independent variables (i.e. patients' age, education and the chaperone's gender) and patient satisfaction with chaperone care, a linear regression test was conducted.

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<sup>58</sup> Correlation coefficients range in value from -1 (a perfect negative relationship) to +1 (a perfect positive relationship). A value of 0 indicates no correlation. Usually values up to 0.3 are described as weak, values greater than 0.3 up to 0.40 as fair, values greater than 0.4 up to 0.75 as moderate, and any value greater than 0.75 as strong (Field, 2012).

**Table 4:** Correlation of statements of care provided by the chaperone

Scales	Items	Correlation (mean [SD] in diagonal)						
		1	2	3	4	5	6	7
<b>Chaperone care</b>	1. My chaperone treated me with respect.	4.92 (0.44)						
	2. My chaperone gave me enough time to describe my health problem.	0.528**	4.77 (0.64)					
	3. My chaperone encouraged me to talk and ask questions.	0.226*	0.300**	4.02 (1.45)				
	4. My chaperone clarified some information about me to my doctor.	0.307**	0.231**	0.387**	4.26 (1.31)			
<b>Chaperone involvement</b>	5. Sometimes, I felt that my doctor focused his attention on my chaperone rather than me.					2.36 (1.64)		
	6. There were some issues that I would have liked to tell my doctor about, but I could not.					0.258**	1.96 (1.52)	
	7. Sometimes, I felt that I was excluded from the conversation.					0.778**	0.368**	2.20 (1.57)

\*\* Correlation is significant at the 0.01 level (2-tailed). \* Correlation is significant at the 0.05 level (2-tailed).

\*\* Correlation is significant at the 0.01 level (2-tailed).

In order to reveal the effect of patients' age, patients' education, and the chaperone's gender on patient satisfaction with chaperone care, a linear regression model was generated. Before starting the linear regression test, there were certain assumptions that had to be followed. First, since the age of the participants of the present study varied, and because there was no specific theoretical reason for selecting a particular variable to be entered first into the regression model, the method of predictor selection was forced entry (or Enter, as it is known in SPSS) (Field, 2012), which requires entering all the predictors of the model at the same time.

Second, to build a linear regression model, dummy variables were created to represent categorical variables. Before creating dummy variables, some of the categories were combined to make the analysis more robust. For example, as previously noted regarding the patients' education, as only two patients had a diploma and only one had a postgraduate degree, these were combined with the term of university degree. In addition, as no patient selected "illiterate school," this category does not appear in the table. Similarly, for the chaperone's gender, as only one patient chose "group" among the options provided for the type of chaperone, this was combined with the category "male and female."

Third, before building a successful linear regression model, the data had to satisfy the following assumptions: (a) all observations should be independent. This means that the researcher ensured that this requirement was satisfied by making sure that her collected data was independent while she gathered it, i.e. checking the same patient did not fill in the questionnaire twice. (b) The data should not suffer from multicollinearity, i.e. the independent continuous variables should not be highly related. To find out if the data suffer from multicollinearity, the tolerances for each of the independent continuous variables in the model had to be examined. If any of the tolerances of the predictors in the data were small (close to zero, for example), multicollinearity could have been a problem. (c) The residual from the model fit should follow a normal distribution. This was checked by producing a histogram plot of the residual. (d) Each of the independent continuous variables should have a linear relationship with the dependent variable. Each of the predictors in the data file was checked against the dependent variable using a matrix scatterplot.



The results relating to the effect of patients' age, education, and the chaperone's gender on patient satisfaction with chaperone care are discussed below.

#### 4.4.2.1. Linear regression with chaperone care as a dependent variable

The results from the coefficients (i.e. level effects model), shown in Table 5 below, indicated that none of the predictors had a significant effect on chaperone care [ $F=1.131$ ,  $p=0.351$  ( $>0.05$ )] overall at the 5% level. For example, chaperone gender [ $t=1.066$ ,  $p=0.289$  ( $>0.05$ )], elementary education [ $t=0.712$ ,  $p=0.478$  ( $>0.05$ )], intermediate education [ $t=-0.743$ ,  $p=0.460$  ( $>0.05$ )], secondary education [ $t=1.179$ ,  $p=0.241$  ( $>0.05$ )], higher education [ $t=-0.248$ ,  $p=0.804$  ( $>0.05$ )] and age [ $t=0.942$ ,  $p=0.349$  ( $>0.05$ )] were not significant at the 5% level. The adjusted R-squared was 0.008104 and the predictors account for less than 1% of the variability of chaperone care.

**Table 5:** Coefficients with chaperone care as the dependent variable

Variables	Estimate	Std. Error	<i>t</i> Value	Pr (>   <i>t</i>  )
Intercept	4.029371	0.441488	9.127	1.87e-14***
Chaperone gender	0.157069	0.147296	1.066	0.289
Elementary Education	0.149606	0.210080	0.712	0.478
Intermediate education	-0.183087	0.246510	-0.743	0.460
Secondary education	0.341218	0.289402	1.179	0.241
Higher education	-0.068554	0.275902	-0.248	0.804
Age	0.006882	0.007305	0.942	0.349

As the data showed no linear relationship between the independent (i.e. chaperone's gender, and patients' education and age) and dependent variables of chaperone care, the analysis of variance (ANOVA), i.e. the main effect model, was carried out next in order to report p values on the predictors.

The analysis of variance (ANOVA) in Table 6 below shows that the main effect of chaperone gender [ $F=0.9388$ ,  $p=0.3352$  ( $>0.05$ )], education [ $F=1.2395$ ,  $p=0.2999$

(>0.05)] and age [ $F=0.8876$ ,  $p=0.3486$  (>0.05)] were not significant predictors of chaperone care at the 5% level.

**Table 6:** Analysis of variance for chaperone care

<b>Variables</b>	<b>Df</b>	<b>SumSq</b>	<b>MeanSq</b>	<b>F value</b>	<b>Pr (&gt;F)</b>
Chaperone gender	1	0.450	0.44968	0.9388	0.3352
Education	4	2.375	0.59370	1.2395	0.2999
Age	1	0.425	0.42517	0.8876	0.3486
Residuals	90	43.110	0.47900		

In summary, while we were expecting to find some effect, the statistical analysis indicates that there was no main effect of the chaperone’s gender, patients’ education (elementary, intermediate, secondary or higher education) and age on patient satisfaction with chaperone care.

In the following section, the findings of the third part of the main research question are discussed, (i.e. the effect of patients’ age, education, and the chaperone’s gender on patient satisfaction with chaperone involvement).

#### **4.4.3. The effect of patients’ age, education and the chaperone’s gender on patient satisfaction with chaperone involvement**

In order to answer the third part of the main research question, i.e. the effect of patients’ age, education, and the chaperone’s gender on patient satisfaction with chaperone involvement, a summary of the chaperone involvement scale is provided—with reference to the descriptive statistics (mean and standard derivation), and correlation between items—followed by presenting the findings of a linear regression test.

As shown in Table 4 above, the mean and standard derivation for the chaperone involvement scale (items from 5-7) suggest that most patients agreed with the statements, as the mean value falls between 2 = agree and 3 = uncertain on the 5-point scale. However, the standard deviation is relatively large, indicating that the responses given by the patients varied substantially. Nonetheless, on average, it is fair to say that the patients seem to be unhappy with chaperone involvement.

With regards to correlation of statements in the chaperone involvement scale, it was found in Table 4 above, that the highest correlation (0.778) was measured between the statements *Sometimes, I felt that my doctor focused his attention on my chaperone rather than me* and *Sometimes, I felt that I was excluded from the conversation*. This correlation is positive, very strong, and significant at the 1% level, indicating a linear relationship. However, this is not a cause and effect relationship. The smallest correlation (0.258) was calculated between the statements *Sometimes, I felt that my doctor focused his attention on my chaperone rather than me* and *There were some issues that I would have liked to tell my doctor about but I could not*. This correlation is positive, weak<sup>59</sup>, and significant at the 1% level. There is a linear relationship between the two statements, but that relationship is weak. Finally, the correlation between the statements *There were some issues that I would have liked to tell my doctor about but I could not* and *Sometimes, I felt that I was excluded from the conversation* is 0.368. This is positive, fair, and significant at the 1 % level, indicating a degree of linear relationship between the two variables.

In order to detect the effect of patients' age, education, and chaperone's gender on patient satisfaction with chaperone involvement, a multiple linear regression is used. The findings of the regression test regarding the effect of patients' age, education, and the chaperone's gender on patient satisfaction with chaperone involvement are presented below.

#### **4.4.3.1. Linear regression with chaperone involvement as the dependent variable**

The results from the coefficients (i.e. level effects model), as shown in Table 7 below, indicate that overall none of the predictors have a significant effect on chaperone involvement [ $F=1.357$ ,  $p=0.2407$  ( $>0.05$ )] at the 5% level. However, looking at the individual variables and at the different levels of education some significant and no significant results can be seen. For example, chaperone gender [ $t=0.758$ ,  $p=0.45071$  ( $>0.05$ )], elementary education [ $t=-0.894$ ,  $p=0.37368$  ( $>0.05$ )],

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<sup>59</sup> Weak (0.258) and fair (0.368) refers to the coefficients not the significance.

intermediate education [ $t=-1.033$ ,  $p=0.30417$  ( $>0.05$ )], and age [ $t=-1.643$ ,  $p=0.10394$  ( $>0.05$ )] are not significant at the 5% level while secondary education [ $t=-2.645$ ,  $p=0.00963$  ( $<0.001$ )] is significant at the 1% level and higher education [ $t=-2.004$ ,  $p=0.04804$  ( $<0.05$ )] is significant at the 5% level. The adjusted R-squared is 0.02182; the predictors accounts for 2.182% of the variability of chaperone involvement.

**Table 7:** Coefficients with chaperone involvement as the dependent variable

Variables	Estimate	Std. Error	<i>t</i> Value	Pr (>   <i>t</i>  )
Intercept	3.51849	0.79004	4.454	2.42e-05***
Chaperone gender	0.19967	0.26359	0.758	0.45071
Elementary Education	-0.33611	0.37594	-0.894	0.37368
Intermediate education	-0.45587	0.44113	-1.033	0.30417
Secondary education	-1.37000	0.51788	-2.645	0.00963**
Higher education	-0.98961	0.49373	-2.004	0.04804*
Age	-0.02147	0.01307	-1.643	0.10394

As the data showed some significant effects between the independent (i.e. patients' education) and dependent variables of chaperone involvement, the analysis of variance (ANOVA) or the main effect comparisons model was carried out on the predictors next in order to report the  $p$  values.

Table 8 below shows the analysis of variance which revealed that the main effect of chaperone gender [ $F=0.3282$ ,  $p=0.5682$  ( $>0.05$ )], education [ $F=1.2787$ ,  $p=0.2843$  ( $>0.05$ )] and age [ $F=2.6983$ ,  $p=0.1039$  ( $>0.05$ )] are not significant predictors of chaperone involvement at the 5% level.

**Table 8:** Analysis of variance for chaperone involvement

Variables	Df	SumSq	MeanSq	<i>F</i> value	Pr (> <i>F</i> )
Chaperone gender	1	0.503	0.5034	0.3282	0.5682
Education	4	7.845	1.9614	1.2787	0.2843
Age	1	4.139	4.1389	2.6983	0.1039
Residuals	90	138.050	1.5339		

To summarise, the statistical analysis indicates that there is no main effect of gender, education or age on chaperone care. However, different levels of education

(secondary and higher) have significant effects on patient satisfaction with chaperone involvement.

#### **4.5. Summary**

In this chapter, I have described the design of the questionnaire employed for collecting data on patient satisfaction and the steps in analysing the questionnaire data. I have discussed the findings of the first main research question in this thesis about the effect of patients' age, patients' education, and the chaperone's gender on patient satisfaction with (1) overall care, (2) chaperone care, and (3) chaperone involvement in three-party consultations. Descriptive statistics on patients' age, education, and the chaperone's gender on patient satisfaction with overall care were presented. Similarly, qualitative findings showed no association between independent (patients' age, education, and the chaperone's gender) and dependent (overall satisfaction) variables with reference to the six dissatisfied patients. Linear regression test showed no effect between independent and dependent variables on patient satisfaction with chaperone care on both the main and level effects models. However, concerning patient satisfaction with chaperone involvement, the linear regression test revealed that only education (secondary and higher) has a positive effect on patient satisfaction with chaperone involvement. In terms of education, patients who had secondary and studied higher education tended to welcome more chaperone involvement than patients who had elementary or intermediate education.

The following chapter presents the thematic analysis findings of the four open-ended questions regarding patients' perceptions about their chaperones' presence in medical consultations.

## CHAPTER 5

### Patients' Perceptions of Chaperones' Roles and Gender Variation

#### 5.1. Introduction

The primary objective of this chapter is to develop an in-depth understanding of the Saudi female patients' perceptions of their chaperones' roles during their medical encounters and any variations in the role characteristics that are related to the chaperone's gender. Therefore, this chapter has been divided into four sections. The first section provides a critical review of past studies on gender variation in three-party consultations. The second section discusses the data analysis methodology for the qualitative data derived from the open-ended questions and presents the six-step guide adopted for conducting thematic analysis. The third section discusses the results of the qualitative thematic analysis regarding patients' perceptions towards their chaperones' supportive roles, plus gender variation in roles. It is hoped that these results will help to develop support services appropriate to patients' needs, as well as assist in providing chaperones with an overview of the kinds of support their sick relatives need the most.

#### 5.2. Gender Variation

As mentioned in the literature review (Chapter 2), qualitatively assessing patients' perceptions regarding their chaperones' roles during their medical appointment, plus the rationale for their attendance, has a significant outcome for both physicians and chaperones in identifying patients' needs as well as improving three-party interactions (Holzmueller, Wu, & Pronovost, 2012; Zanini et al., 2014). Therefore, exploring chaperone's roles during medical encounters, from the patients' perspective, is not complete without examining the association between chaperone role and gender variation in roles.

Authors of studies on gender variation in the quality and type of care provided for patients, conducted in the USA, (Allen, 1994; (Dwyer & Coward, 1991; Mathiowetz & Olikier, 2005), the UK, (Collins & Jones, 1997; Dahlberg et al., 2007)

and Stockholm, (Almberg et al., 1998; Graström et al., 1992), have consistently highlighted the fact that female chaperones are the primary care source (Allen, 1994; Almberg et al., 1998; Dahlberg et al., 2007; Mathiowetz & Olikier, 2005). Numerous studies have shown that the female chaperone is either a spouse or an adult child (Graström et al., 1992; Stone & Kemper, 1989) and that females care for a parent or spouse more often than males do (Dwyer & Coward, 1991; Miller & Cafasso, 1992). Women are also more likely to provide patients they care for with emotional support than males are (O'Grady, 2005; Seigfried, 1989). Women also spend a greater number of hours caring for patients (Almberg et al., 1998) and provide a greater level of help with common daily activities, such as housework and meal preparation (Collins & Jones, 1997; Miller & Cafasso, 1992). Female chaperones' care role is not restricted solely to house-related tasks (such as bathing, dressing, feeding, etc.) but with other necessary activities, such as accompanying the patients to their medical appointment.

Studies exploring the characteristics of three-party medical consultations have indicated that the majority (80%) of patients' chaperones involved in physician-patient interaction are females (Baker et al., 1997; Brown et al., 1998; Glasser, Prohska, & Roska, 1992; Prohska & Glasser, 1996). Wives are generally accompanied by their husbands while wives or daughters usually accompany geriatric patients (Glasser et al., 1992). In the study conducted by Ellingson (2002), the author reported that sometimes more than one chaperone accompanied the patient and attended the medical visit. While previous studies on three-party interaction have mostly focused on the role and effect of the chaperone on physician-patient interaction (Brown et al., 1998; Clayman et al., 2005; Ellingson, 2002), the effects of the chaperone's gender on patients' perception of his/her role during the medical visit has not been given due attention (Beisecker et al., 1996; Clayman et al., 2005, Ellingson, 2002).

A limited number of preliminary articles have discussed the association between the chaperone's gender and role from different perspectives, including (1) physicians' perceptions (explored via semi-structured interviews) (Beisecker & Moore, 1994), and (2) researchers' direct observations of the consultations using either audio-recordings (Ellingson, 2002) or video-recordings of the visit (Clayman et al., 2005). However, the aforementioned studies were conducted in the USA and thus provide geographically and culturally limited information on the relationship between the

chaperone's gender and role. They were further limited by being conducted in a geriatric oncology setting (Ellingson, 2002), a primary care setting with geriatric patients (Clayman et al., 2005), and during an oncologist's visit (Besisecker & Moore, 1994). In addition, in these studies, the researchers investigated the association between chaperone gender and role by focusing only on informational and emotional support.

Besisecker and Moore (1994) asked the male and female oncologists that took part in their study to share their perceptions regarding the male and female chaperones they had interacted with during medical consultations. According to the authors, female physicians characterised male chaperones as protective and confrontational and reported that they tended to gather more information and be more active participants in decision making. However, male physicians found no gender difference in chaperones' roles, with the exception of older female chaperones that were described as more assertive and questioning. Additionally, although male and female chaperones tended to be equally active in asking questions, the authors claimed that they did so with a different purpose. More specifically, according to the authors, male chaperones asked questions to help the patient with decision-making, whilst female chaperones questioned physicians on learning how to care for their sick relatives. Conversely, in the study conducted by Clayman et al. (2005), female chaperones were found to be more verbally active and expressive than their male counterparts when interacting with physicians. In addition, they were more dominant in facilitating patients' participation compared to male chaperones. With regards to memory aid, Ellingson (2002) observed that male cancer patients in her study frequently sought help from their wives when information was requested from them or for verification of facts. This indicated that female chaperones functioned as a sort of memory aid for the male patients.

With regards to emotional support, Ellingson (2002) and Beisecker and Moore (1994) reported that female chaperones were more active than male chaperones in providing emotional support for their sick relatives. More specifically, Beisecker and Moore (1994) noted that female chaperones were "keyed into emotional support and expressing care" (p. 35). However, Ellingson's (2002) investigation on gender variation was limited to memory aid and emotional support only.



Based on the findings discussed above, it is worth making some general observations. First, given the complexity of male and female physicians' observations regarding the role of male and female chaperones in medical consultations in Beisecker and Moore's study (1994), it may be that male and female chaperones behave differently with male and female physicians. It may also be that male and female physicians perceive the same behaviour differently (or fail to notice certain behavioural differences), or it may be a combination of the two. Second, information regarding the supportive roles has thus far been limited to small-scale studies with restricted patient samples. Therefore, the following research question was asked:

**What are the perceptions of the Saudi female patients regarding their chaperones' roles during their medical visits and do chaperones' roles vary according to chaperone gender?**

In answering this question, this study aims to contribute to the sparse body of research on gender variation in three-party interactions during a medical visit in Saudi Arabia. The effect of Saudi culture is examined by gathering and analysing Saudi female patients' perceptions about variation in their chaperones' roles during their medical encounter. Therefore, the next section discusses the open-ended questions data and the steps used in analysing patients' responses using thematic analysis based on the work of Braun and Clarke (2006).

### **5.3. Data Analysis Methodology**

This chapter discusses the four open-ended questions used to collect the qualitative data required for meeting the study objectives and answering the research questions. As discussed in Chapter 4, the quantitative questionnaire contains qualitative data, consisting of four open-ended questions about patients' experiences of having their chaperones present during the medical visit. The goal was also to explore Saudi female patients' perceptions regarding the role of their chaperones during the medical encounter and to investigate gender differences in the chaperones' roles. In response to the four questions below, patients were asked to write down their own answers in a separate boxes which were also included.

1. How do you rate your chaperone today?
2. Overall, what (if anything) was GOOD about having your chaperone with you?
3. Overall, what (if anything) was NOT GOOD about having your chaperone with you?
4. If you have any additional comments regarding male or female chaperones, please write them below.

Although the questions above do not mention gender, gender differences in certain chaperones' roles were determined by the patients' direct and specific reference to their chaperones in their responses to the questionnaire items, for example, the name of the chaperone, (e.g. Amira, or, my son, my daughter, my husband), she (i.e. referring to the patient's daughter, mother, sister), he (i.e. referring to the patient's father, husband, son), or a reference to the consultation on the present day (e.g. in this clinic, today). This procedure facilitated the exploration of the differences in the way male and female chaperones fulfilled their roles.

By asking open-ended questions in the questionnaire, the respondents would provide a wide variety of responses and rich descriptions of their experiences. When allowed to respond to questions in their own words, patients are able to express their own experiences regarding the presence of their chaperones. Moreover, this method allows the patients to provide expressive and spontaneous responses to yield interesting themes during coding and thematic analysis of the gathered data (Gray, 2009; Reja et al., 2003). Finally, providing space for any additional comments (i.e. for question 4 above) acts as a "safety net," (O' Cathain & Thomas, 2004, p. 2), thus ensuring that no important issues are omitted during the data collection process. Such open questions have some of the characteristics of qualitative research, as they help patients identify new issues pertinent to their general experience. When responding to this prompt, patients who took part in the present study were more inclined to provide further details about the advantages of being accompanied by chaperones compared to the responses they gave to the first two questions. Thus, allowing the respondents to provide further details not only assisted in revealing new issues, but also prompted some patients to elaborate on the responses to the preceding questions.

For the open-ended questionnaire responses that were analysed, it was observed that 108 female patients completed the four open-ended questionnaire data. As seen in Table 9 below, patients' responses can be summarised as follows: 103 patients indicated positive attitudes regarding their chaperones, of which 51 were commenting on a male chaperone, 43 on a female, and 9 on a group of chaperones. Five patients indicated negative attitudes toward their chaperones, of whom three had a male chaperone, one a female, and one was accompanied by a group. In nine cases, the data was missing. To answer the research question in this chapter, only positive attitudes towards male (51) and female (43) chaperones were analysed and compared. For group chaperones, gender variation was not clear in patients' responses as they tended to refer to their chaperones as 'they', (e.g., they are supportive). Therefore, responses yielded by patients with group chaperones were disregarded.

**Table 9:** The number of participants who answered the four open-ended questions

	<b>Male</b>	<b>Female</b>	<b>Group</b>	<b>Total</b>
<b>Positive</b>	51	43	9	<b>103</b>
<b>Negative</b>	3	1	1	<b>5</b>
<b>Missing</b>	4	3	2	<b>9</b>
<b>Total</b>	58	47	12	<b>117</b>

Once the data collection stage was completed, the qualitative data (i.e. patients' responses) were coded in Arabic by the researcher before being analysed. Then the data were translated into English by the researcher. The translation from Arabic into English may have impacted on the data analysis. Certain Arabic words have an English equivalent but are sometimes confusing. One example that was confusing when translating the patients' views was that when the patient wrote that she prefers either her male or female chaperone 'to talk to' or 'speak to' the doctor. Although the words 'talk to' and 'speak to' share the same meaning, it was not clear whether the patient prefers her chaperone 'to talk on her behalf' most of the time or just 'clarify' certain information to the physician while she continues talking to the doctor about her

complaint. For this reason, throughout the translation words like these were discussed further with both an independent native Arabic speaker and an English PhD candidate, in order to check that the final transcript conveyed the sentiments (i.e. expressed by patients) as clearly as possible, as transcripts could not be returned to patients for validation.

In order to test the reliability of the coding process (Fereday & Muir-Cochrane, 2006), two PhD colleagues were invited to code all the translated qualitative (i.e. open-ended questions) data from the start (see Chapter 3 about trustworthiness of qualitative data). The first colleague was an Arabic native speaker from the Moray House School of Education, Edinburgh University, whilst the second was an English native speaker from the School of Philosophy, Psychology and Language Sciences, Edinburgh University. Both colleagues were chosen for this task due to their extensive experience in qualitative thematic analysis. Their respective coding results were subsequently compared and modified to elicit the desired ideas. Moreover, the analysis of the empirical data and the findings of this study were discussed with the two supervisors of this research.

Therefore, the qualitative responses of the open-ended questions data provided by the study participants were analysed using thematic analysis based on the work of Braun and Clarke (2006). The next section presents a thematic analysis summary and the steps followed to analyse the patients' responses.

### **5.3.1. Thematic analysis**

Thematic analysis is a commonly used method in qualitative research. However, it is poorly documented (Braun & Clarke, 2006), as there is no fixed rule for coding qualitative data (Saldaña, 2009). Thematic analysis involves identifying, coding, describing, and analysing the recurrent patterns or themes within the data in great detail (Braun & Clarke, 2006). These themes are the core information yielded, and help convey the story presented through the data to the readers (Taylor & Ussher, 2001). According to Braun and Clarke (2006) thematic analysis is a “realist method” (p. 9), reporting the participants' realistic situations and experiences. Thematic analysis was chosen to analyse the open-ended questions data in the current study for several reasons: (1) to gain a detailed understanding of patients' real experiences about the

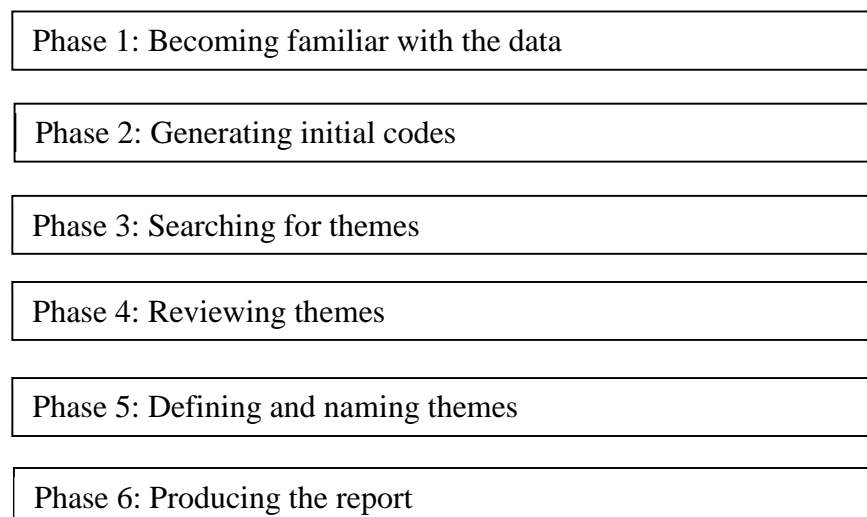
role of their chaperone during their medical visit, (2) to explore the main themes that emerged from self-reporting of individual patients' experiences, (3) to enable comparison between male and female chaperones regarding the supportive behaviour they provided for their female patients, and (4) to use the findings of this study to identify the supporting roles that patients require, as well as to develop the supporting role services according to patients' needs and concerns.

To conduct the thematic analysis, systematic step-by-step guidelines were employed, as described in the subsequent sections.

#### **5.3.1.1. Conducting thematic analysis using step-by-step guidelines**

According to Braun and Clarke (2006), the coding process should be a "recursive" (p. 15) one which follows specific guidelines. It allows back and forth movement through the data as a whole, as the coded extracts of data are analysed, and the analysis is produced. The six stages of manual coding are presented in the chart shown in Figure 5. The choice of manual coding, as a crucial aspect of data analysis, was significant in this study, as it assisted in the organisation of the related coded data and making sense of the findings (Basit, 2003). For example, words and sentences related to each other were classified into small categories, (e. g., talk on behalf of, speak to the doctor) (see Appendix 14). In addition, the manual coding also provides a comparative list when working with gender differences (i.e. male and female supportive roles) that were strikingly apparent in patients' perceptions (see Appendix 15). The six phases of analysis adapted from Braun and Clarke (2006) are described in more detail in the following text.

**Figure 5:** Six stages of manual coding, (adapted from Braun & Clarke, 2006)



#### **5.3.1.1.1. Becoming familiar with the data**

This phase requires two important sub-phases: (1) preparing data for the analysis, and (2) commencing close observation of the data. In the context of the present investigation, the former step involved putting and organising the data into four-column tables (see Appendix 16). The first column includes patient information, for example, the patient's number as it appears in the coding of the questionnaire data (see Chapter 4), age, education status, her chaperone and his or her relationship with the patient.<sup>60</sup> The second column includes the patient's responses in Arabic<sup>61</sup> to the qualitative open-ended questions<sup>62</sup>, along with the English translation. In the third column initial codes are generated, while the fourth column allows for notes about initial thoughts concerning the themes.

The second sub-phase requires the researcher to immerse herself in the data. This involves careful repeated reading of all the Arabic transcripts along with their English translations, searching for interesting patterns or themes, while also gaining familiarity with the data. This process facilitates and informs the subsequent stages of

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<sup>60</sup> Such information is important when using quotes in the analysis to refer to the point in the transcript that this quote comes from (which patient, gender of the chaperone, etc.).

<sup>61</sup> For a thorough analysis, I added the patients' Arabic responses in order to check the meaning of some sentences with an independent native Arabic speaker and an English PhD candidate.

<sup>62</sup> Some patients added positive comments, some added negative only, while others added both.

the analysis (Braun & Clarke, 2006). Once fully familiar with the data collected, the researcher moves onto generating the initial codes.

#### **5.3.1.1.2. Generating initial codes**

Generating initial codes requires the researcher to create labels using a single word that is meaningful and pertinent to a segment of data (Boyatzis, 1998). Such multiple labels or codes can be described as the building blocks for creating themes, which is an important aspect of the next phase of the thematic analysis process (Braun & Clarke, 2006; Gibson & Brown, 2009). In the present study, the codes assigned to the data were determined by what the patients wrote about their chaperones (e.g. “He brought me to my appointment today” or “she reassures me”), how they described their chaperones’ roles, and what activities their chaperones performed during the medical visit (e.g. “he talked to the doctor,” or “he clarified for the doctor things that I could not say”).

Therefore, the data extracts sourced from the completed questionnaires were coded using manual coding in a separate computer file. A separate column named “codes” was created next to each patient’s quote (see Appendix 16). During this process, patients’ quotes were examined line-by-line, and one code was assigned to each line in the data set by creating a small number above the line of each data extract/set (e.g. “He drove<sup>1</sup> me to the hospital,” or “I felt comfortable<sup>2</sup> when my son accompanied me”) (see Appendix 16). According to Ellingson (2002), such a micro-analysis of each line forms the basis of searching for themes across the data set as explained in the next phase.

#### **5.3.1.1.3. Searching for themes**

In this phase, the list of different codes that were extracted from the data set was grouped for similarity. Based on this similarity, these codes were classified into three main themes: emotional support, informational support, and logistical support. In order to classify the different codes into themes and visualise the relationships between the listed codes and potential themes, tables were created. They served as a visual representation and were constructed by writing the name of the first theme as the main heading, followed by the codes that were related to it. In addition, all the relevant

extracts from the data that represent a specific theme were also included in the visual table (see Appendix 14 as an example). Based on this visual table, other tables were also created to investigate the relationship between the chaperone's gender and role. This helped in identifying the most important theme (or role) for the patient and whether male or female chaperones performed that theme (role) more often (an example is given in Appendix 15). Once all overarching themes were identified, they were revisited, along with their relevant extracts, as discussed below.

#### **5.3.1.1.4. Reviewing themes**

This phase is an essential part of qualitative data analysis, as it allows some themes to be refined, combined, separated, or even discarded (Braun & Clark, 2006). Therefore, all the patients' extracts which represented each theme were read and revised. Some data extracts in the first theme (i.e. emotional support, such as "she helps me when I am sick") were transferred to the third theme (logistical support). After revising all the patients' extracts, the three themes were clarified in order to make sure that each had a coherent relation to the data set. By the end of this phase, the overall story regarding the three themes emerged based on patients' accounts of their experiences. What still needed to be done was to define and refine the themes, as shown in the next stage of the analysis.

#### **5.3.1.1.5. Defining and naming the themes**

The processes performed in the preceding phases of the data analysis resulted in three themes describing how female patients characterise their chaperones' support. In defining the themes, three steps were carried out. First, the importance of each theme was identified. Second, the interesting features of each theme were determined. Finally, the aspects that each theme captures were described to give a precise picture of the identified theme.

The following section presents the results of the open-ended questions data in relation to the research questions stated above.



## 5.4. Thematic Analysis Results

To review, the aim of this chapter is to discuss the thematic analysis findings of the second research question of this thesis as seen below:

**What are the perceptions of Saudi female patients regarding their chaperones' roles during their medical visits and do chaperones' roles vary according to chaperone gender?**

The result of this question has been divided into two parts. The first part reports patients' perceptions regarding their chaperones' positive roles. The second part deals with the findings regarding gender variation in the chaperone's role. In discussing the results of the thematic analysis of the four open-ended questions, it is important to give a summary of the procedure I followed in reporting the results of this chapter.

For the presentation of the results of this study, frequencies were used in order to identify the most important chaperone's role from the patients' perspective. For this purpose, the emergent themes were organised in tables, along with the percentage of each theme and its sub-themes (see Table 10), following the approach adopted by Beisecker et al., (1996), who presented the most important roles of chaperones based on patients' reports. Gender variation was also presented under each theme, along with the corresponding percentage, to determine gender differences in roles and ascertain whether males or females exhibited this behaviour more frequently. Although frequencies and percentages are not necessary for presenting qualitative data, they do help establishing which themes are commonly shared by the participants (Toerien & Wilkinson, 2008). In addition, the number of participants<sup>63</sup> who mentioned a particular theme/role with reference to their chaperones was also tabulated, followed by a percentage (see Table 10). A direct quote and the number of participants who addressed that particular theme were also provided. For the sake of patients' anonymity, each individual was assigned a code, comprising a combination of a letter and a number (e.g. P37, where P refers to "Patient" and the number corresponds to the questionnaire number). The answer to the first part of the second main research question of this thesis is discussed in the following section.

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<sup>63</sup> Who were either accompanied by male or female chaperones.

### **5.4.1. Patients perceptions about chaperones' roles**

Three main themes emerged from the thematic analysis of the patients' responses about the role of their chaperones during their medical visits. These overarching themes are displayed in order of descending importance to the female patients, and presented in Figure 6. The themes are: (1) emotional support, (2) informational support, and (3) logistical support.

#### **5.4.1.1. Emotional support**

The female patients who took part in this study indicated that their chaperones provide them with emotional support during their medical visits. To them, emotional support means a feeling of psychological comfort when a chaperone is physically present and verbally reassures the patient during the medical encounter. Both aspects of emotional support are illustrated below with reference to the patients' quotes.

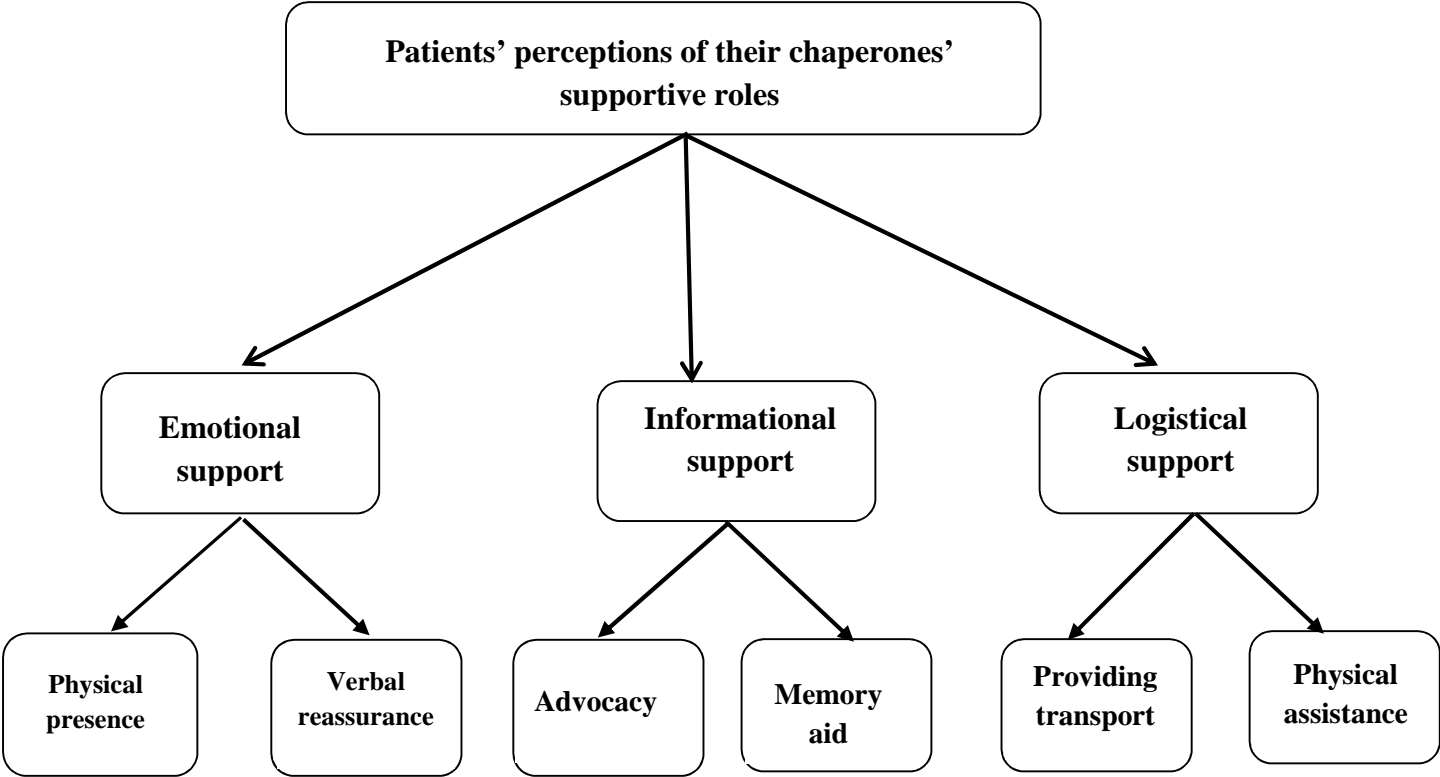
Female patients indicated that they considered their emotional needs were satisfied by the presence of their chaperones<sup>64</sup> who supported them. The presence of the chaperones gave a feeling of comfort, security and relief during the medical consultations. Almost all the female patients who were accompanied by female chaperones reported that their physical presence (40, 93%) comforted them compared to being accompanied by a male chaperone (10, 20%). A 47-year-old cancer patient reported:

I feel comfortable when somebody comes with me to the clinic. I do not want to feel lonely. My daughter came with me today. She is close to me. She is my friend. Her presence gives me a feeling of psychological comfort and relief. (P38)

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<sup>64</sup> Five patients who were unhappy with their chaperones were eliminated from the analysis.

**Figure 6:** Perceptions of the support provided by male and female chaperones for their female patients



Conversely, patients indicated that the absence of their chaperones causes a feeling of discomfort and pain, as shown in the following quote:

When I enter the clinic by myself, the situation is very difficult. I have a feeling of pain, suffocation, and being uncared for. (P49)

Not only is chaperones' physical presence a source of comfort to the majority of patients but they also offer verbal reassurance to the patients. Patients emphasised the importance of this verbal reassurance, as it calmed and comforted them during the medical visits. According to the female patients that responded to the open-ended questions, verbal reassurance included the chaperones' verbal support by consoling them, offering reassurance of a cure and alleviation of suffering, especially when the patient received bad news. Patients also reported that such a reassuring attitude from the chaperone during this stressful time is important, as it helps keep them calm and relaxed. Moreover, female patients mentioned that they value their female chaperones' verbal reassurance (86%) compared to their male counterparts (43%). A 47-year-old patient reported:

When I heard the bad news from the doctor, her presence [the patient's daughter's] alleviated my health problem, and lessened my disaster. She reassured me. She made me calm and comforted me. She amused me and took me out of the situation I was in. (P89)

The physical presence of a comforting chaperone, as well as the chaperone's verbal reassurance, meets patients' emotional needs and helps moderate their reactions. Fulfilling these needs makes a positive difference to the patients' experiences. A 45-year-old patient described her emotional needs by saying:

I do not feel illness when my daughter is with me. She boosted my spirits, especially when I heard something harsh from the doctor. Her presence helps to calm me down. She puts everything into perspective. However, when I went alone, I felt vulnerable and offended. I prefer her to be with me to put me at ease. (P101)

#### 5.4.1.2. Informational support

Female participants reported two aspects of informational support, namely advocacy and memory aid. Patients indicated that chaperones played an important role during the visit by advocating for them. The advocacy role, according to the female patients, includes the verbal support that the chaperone offered by speaking to the medical professionals on their behalf about their health and the treatment options. Thematic analysis revealed that some illiterate female patients (10 %) preferred their female chaperones' involvement (i.e. speaking on their behalf) because of their poor literacy. Other patients (10%) wrote that they felt shy while discussing intimate subjects, so they described themselves as dependent on their male chaperones. This attitude is exemplified in the following quote, shared by a 21-year-old patient:

I depended on him [her husband] to speak on my behalf. I feel shy when I speak to a male doctor about things in obstetrics and gynaecology. I need him to speak on my behalf. If he makes a mistake, I will correct him. (P22)

A 60-year-old patient justified her preference for a male chaperone to speak on her behalf by saying:

I depend on him [her son] to speak on my behalf. He speaks better than I do. I think when a man speaks to a man, they understand each other better. The doctor understands him more than me. The female patient feels shy, whether she is in an inpatient or outpatient clinic. (P68)

However, some patients (10%) reported that they preferred their female chaperones to speak on their behalf because of their poor literacy. Some also wrote that they did not know how to speak to their physician. As was noted by a 56-year-old illiterate patient, who needed her daughter to speak on her behalf:

I am not educated. I am illiterate; I don't know how to speak. Amira is the closest one to my heart among her sisters. She always speaks on my behalf. The doctor understands her more than me. (P88)

The second aspect of chaperones' informational support pertained to their role in memory aid. Data analyses revealed that half of the female patients (22, 43%) rated

this role as important. Patients reported that their chaperones recalled their symptoms, drug names, and their upcoming appointments. A 20-year-old patient wrote:

He [her husband] had an important role today. He reminded me of the symptoms I had been facing that I could not remember. He reminded the doctor of the drugs I was taking in the past. (P115)

In short, both the advocacy and the memory aid offered to the patients by their chaperones were deemed necessary and important to the female patients. A 32-year-old patient summed this up very well:

His role [her husband's] was important today. He spoke to the doctor . . . He notices the changes in my health and tells the doctor. When I am sick and cannot speak, he speaks on my behalf. He tells the doctor the symptoms if I forget them. (P28)

#### **5.4.1.3. Logistical support**

The third theme that emerged from participants' questionnaire responses pertained to patients' needs for logistical support. Female patients mentioned two aspects of the caring tasks undertaken by their chaperones, (1) providing transport, and (2) offering physical assistance. Those who were accompanied by male chaperones (38, 75%) regarded providing transport to attend their medical appointment as a significant part of the chaperone's caring role.

More than half of the patients reported that even though their male chaperones are employed full-time, they gave priority to their relatives' appointments over their work commitments. Thus, they took time off from their work to take the patients to their appointments. A 48-year-old patient commented on her son's logistical support:

I came from Albaha<sup>65</sup> to Jeddah. It took around nine hours by car. My son cares about me. He provides transport. He has asked permission from his work to take me to the hospital. He tries to satisfy me. (P76)

Most female patients received logistical assistance from their male chaperones who helped them by providing transport. Saudi women are not allowed to drive on public roads within Saudi Arabia. Thus, they depend on their male relatives, such as

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<sup>65</sup> Albaha is a small town in the Southern part of Saudi Arabia

fathers, husbands, or brothers, to drive them to certain places. Providing transport is an important need for female patients, particularly those who live a significant distance from the hospital, and those whose male chaperones are employed full-time.

The second aspect of logistical support that emerged from open-ended question data was that of providing physical assistance to the patients. Female patients appreciated their chaperone's physical assistance, by (1) making their appointments and arranging follow-up visits and (2) dressing them. Female patients reported feeling comfortable and relaxed, knowing that someone is caring for them and helping them physically. A 48-year-old patient wrote:

She [her daughter] cares about me. She is keen to arrange my appointments and follow-ups. She is worried about me. She is the one who made this appointment with the doctor. I cannot go to the appointment registry office. It is far from here and my sight is weak. Her presence made me relaxed. (P106)

Interestingly, when responding to this question, a quarter of the patients did not refer solely to their chaperone's role in the hospital, but went further and mentioned the assistance they received at home. They perceived the physical support they received from their female chaperone as a kind of care, especially, if they were close to their chaperones. They reported that, being closely related and comfortable with the patients means the female chaperones can change and dress them, especially at home. A 60-year-old patient reported:

My daughter as a chaperone is important for me. She is close to me. If I am sick and uncovered, she covers me, changes my clothes, especially at home. (P60)

Patients with female chaperones expressed a preference for their female chaperones' physical assistance, in particular with physical aspects of care, such as dressing them. This view was expressed by a 49-year-old patient, who noted:

I prefer my daughter to dress me and change my clothes. She is close to me. I feel shy with my son. He is a man. (P115)

To summarise this section, the three important themes that were identified in the Saudi female patients' accounts of their experiences with their chaperones during their

medical appointments were emotional support, informational support, and logistical support. The patients' responses indicated that their chaperones facilitated their emotional, informational, and their logistical support. These supportive roles were essentially the rationale behind their need for their chaperones' attendance.

While these are important findings, as the participants demonstrated a preference for male or female chaperones in meeting their specific needs, this association between the chaperone's role and gender was further investigated. The following section discusses the second part's answer to the second research question.

#### **5.4.2. Association between the chaperone's role and gender**

This section discusses the findings of the second part of the second main research question in the thesis. The research question is:

**According to patients' perceptions, do male chaperones differ from their female counterparts in terms of the supportive roles they offer to their relatives during a medical visit?**

Table 10 below provides summary frequencies describing the supportive role of both male and female chaperones during the medical visit, as reported by female patients. Gender variation was examined for three domains which were identified as emerged themes—emotional, informational, and logistical support.

With regards to emotional support, as shown in Table 10 below, gender differences in patients' perceptions became strikingly apparent. For example, when the patients' responses regarding the support provided by male and female chaperones were analysed, it was evident that female patients who were accompanied by female chaperones indicated that their female chaperones were more likely to support them physically by attending the medical visit with the patient (40, 93%) and by verbally reassuring them (37, 86%).



**Table 10:** Female patients' perceptions of the support provided by their male and female chaperones (expressed as percentages)

Chaperones	Female patients ( <i>n</i> = 94)						
	Accompanied by:						
	Male chaperones ( <i>n</i> = 51) & Female chaperones ( <i>n</i> = 43)						
	Emotional support		Informational support		Logistical support		
Physical presence	Verbal Reassurance	Advocacy	Memory aid	Providing transport	Physical assistance		
		Speaking for the patient			Making appointment	Dressing the patient	
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Male	10 (20%)	22 (43%)	29 (57%)	22 (43%)	38 (75%)	8 (16%)	1 (2%)
Female	40 (93%)	37 (86%)	24 (56%)	8 (19%)	-	18 (42%)	7 (16%)

On the other hand, nearly half of the respondents, who were accompanied by male chaperones, indicated that they relied on their verbal reassurance (22, 43%) whereas less than a quarter (very few) (10, 20%) mentioned that their male chaperones supported them emotionally by physically attending the clinic with them. Clearly, female patients preferred to receive emotional support from female chaperones, as they seemed more comfortable having a woman in this role.

In terms of informational support, patients' perceptions of their chaperones' informational support differed by gender in some aspects but were similar in others. For example, in terms of the chaperones speaking on behalf of the study participants, the results showed that more than half of both the male (29, 57%) and female chaperones (24, 56%) were valued for advocating for the patients. In this respect, there is no significant difference between the value patients assigned to either their male or female chaperones. With regards to memory aid, nearly half of the male chaperones (22, 43%) acted as a memory aid which was more than their female counterparts (8, 19%).

Regarding gender differences in giving logistical support to the patients as shown in Table 10, only male chaperones (38, 75%) could provide transport for their female relatives, as it was not possible for their female counterparts to drive their sick relatives, due to Saudi law. However, a significant gender difference was found in providing physical assistance for the patients. Specifically, a quarter of the female chaperones (18, 42%) tended to make appointments for their sick relatives compared with their male counterparts (8, 16%). Similarly, female chaperones (7, 16%) were more likely to dress their female sick relatives, as this was almost never done by their male counterparts (1, 2%). Thus, aside from providing transport, male chaperones were far less physically supportive of the patients compared to their female counterparts.

In short, although the number of male chaperones in this study was higher than that of their female counterparts, this did not indicate that female chaperones had less important supportive roles. The female chaperones met a greater number of patients' needs and did so more frequently than their male counterparts (as they provided emotional support and physical assistance). On the other hand, male chaperones acted as a memory aid more often than their female counterparts did.

## 5.5. Summary

In this chapter, I have provided a critical review of gender variation in roles from previous research on three-party interactions. I have discussed the methodology in analysing the patients' responses that emerged from the four open-ended questions data. I have also explained the phases of thematic analysis adapted from Braun and Clarke (2006) in analysing the qualitative data (i.e. patients' perceptions). In addition, I have explored in this chapter Saudi female patient's perceptions regarding their chaperones supportive roles during their medical visits in order to verify whether there are significant gender differences in the care provided to patients in Saudi Arabia. Thematic analysis of the open-ended questions revealed three main themes, (i.e. emotional, informational, and logistical support) that clarified chaperones' roles and gender variation. Findings have shown that female patients valued the emotional support they received from their female chaperones more than their male counterparts. With regards to informational support, results have indicated that both genders were equally likely to be active in an advocacy role, particularly, in speaking on behalf of patients for minor reasons (i.e. patient's being shy or illiterate). However, in terms of memory aid, findings have shown that male chaperones were more active as a memory aid than their female counterparts. Findings from logistical support have indicated that female chaperones were more active than their male counterparts in assisting the patients physically by making appointments and dressing them.

What is interesting in this chapter is that knowing more precise details of what patients reported about their chaperones' attitudes can help to pinpoint more precisely their priorities and needs and gender variation in the supportive roles. The findings yielded may enable chaperones to find a balance between patients' perceptions and their supportive roles. The results of this study are also expected to contribute to the efforts to improve physician-patient- chaperone interaction, as well as fulfil patients' needs by delivering patient-centred care.

In addition, although the themes that emerged from the patients' responses are not very detailed, they add to the quantitative analysis. For example, the statistical analysis, (in Chapter 4), showed that patients' education has a significant effect on patient satisfaction with chaperone involvement. In the thematic analysis, less than a quarter of patients who were accompanied by female chaperones reported their

preference for their female chaperone to speak on their behalf because of their poor literacy. In addition, findings from the statistical analysis (see Chapter 4) revealed that patients' age has no significant effect on patient satisfaction with chaperone involvement. In the thematic analysis, less than a quarter of the younger patients accompanied by their male chaperones mentioned that they preferred their male chaperone to speak on their behalf especially when discussing intimate subjects (see Chapter 8 for more information about integration and comparison of findings).

On integrating the quantitative and qualitative findings of the current study, discrepant results can be observed. It was found in Chapter 4 that education matters for chaperone involvement, whereas here in Chapter 5 literacy matters but the two issues are not the same. With regards to age, the findings in Chapter 4 demonstrated that age showed no effect on patient satisfaction with chaperone involvement whereas in Chapter 5 age has an impact on patient satisfaction. This complicates the picture as we are not sure whether age and education are treated as the same or different. Such discrepant findings or relationships in Chapters 4 and 5, with regards to patients' age and education, will be observed in the following chapter, whether or not both variables matter with regard to chaperone involvement in the actual third party medical consultation.

Therefore, what still needs to be done is to re-evaluate patients' satisfaction and expectations (regarding their chaperones' supportive roles and gender) in a real-life context by observing the chaperone facilitative role in three-party consultations as seen in the following chapter about alignment.

## CHAPTER 6

### Alignment in Three-party Medical Consultations

#### 6.1. Introduction

In Chapter 5, thematic analysis of open-ended questions revealed that both female and male chaperones were equally likely to speak on behalf of the patient during the medical visit. This chapter validates patients' perceptions regarding their chaperones' advocacy roles by observing how such facilitative roles are practised in reality. Therefore, the aim of this chapter is to examine in close detail the emergence of alignment in three-party medical consultations using Conversation Analysis (henceforth referred to as CA). More specifically, I focus on examining the sequential organisation of alignment, that is, the interactional resources that a male doctor, a female Saudi patient, and her male/female chaperone use to achieve mutual alignment. The analysis aims to contribute to the study of three-party interactions, particularly in medical encounters. Thus, this chapter is divided into three sections. In section 6.2, I review the CA literature on alignment followed by CA studies of alignment in three-party medical interactions. In section 6.3, I describe the analytic process which is followed by analysing the audio-recorded data. In 6.4, I discuss the findings yielded by this study. I end the chapter with a summary of the main findings which arose from the CA.

#### 6.2. Alignment in Conversation Analysis Studies

##### 6.2.1. Alignment and affiliation

Alignment is an important element in achieving meaningful as well as cooperative interaction (see Chapter 2). In social interaction, speakers face each other and jointly, moment by moment, turn constructional unit by turn constructional unit, converse in order to respond to each other in a meaningful and cooperative way and to accept the interactional roles and the social relationship that exists between them (Steensig, 2013; Stiver, Mondada, & Steesig, 2011). Accepting the interactional roles that are logically ordered with prior turn - between interlocutors - represents a set of

norms which are strongly related to participants' understanding of these norms. For example, on presenting a complaint, the speaker (i.e. the patient) treats the doctor as a recipient. When the recipient (i.e. the doctor) responds to the action (i.e. giving help or treatment), he/she positions him/herself vis-à-vis the patient's complaint (Stiver et al., 2011). Therefore, the doctor may respond by showing agreement, or sharing the same opinion on a particular state of affairs, which are the main forms of cooperative action at the patient's request (Stiver et al., 2011). Such cooperative actions are governed by social norms that have an impact on the social relationship between the speaker and the recipient. The social norms are manifested in two forms of cooperation, namely alignment and affiliation.

The terms *alignment* and *affiliation* are used more or less synonymously in extant literature, even though *agreement* and *preference* have been adopted by some authors (Streensig & Drew, 2008). Recently, a clear distinction between alignment and affiliation was suggested by Stivers (2008), in her analysis of the interactional resources (both verbal and non-verbal) participants use to display alignment and affiliation during storytelling. According to Stivers (2008), when a recipient shows alignment with the storyteller, this means that he/she is supporting "the structural asymmetry of the storytelling activity" (p. 34). Structural asymmetry, according to Stivers (2008), refers to the turn taking in storytelling, indicating that the teller holds the floor until the end of the story. Alignment can be demonstrated in storytelling by (1) giving appropriate responses to the interrogator; (2) using "continuers" or "acknowledgement," such as *uh huh*, *mm hm*, *yeah* (Stivers, 2008: 32); and (3) using immediate laughter. These and similar aligning tokens play an important role in contributing to the progress of the story (Gill et al., 2001; Gill et al., 2009; Stivers, 2008).

Stivers et al., (2011) subsequently developed and extended the definition of alignment by arguing that alignment refers to the "structural level of cooperation" (p. 20), and that aligning responses "cooperate by facilitating the proposed activity or sequence; accepting the presupposition and terms of the proposed action or activity; and matching the formal design preference of the turn" (p. 21). This indicates that cooperation is achieved through structural organisation that reveals accepting the

interactional roles among the participants—namely, the roles of a storyteller and a storytelling recipient (Stivers, 2008).

In contrast, the term *affiliation* refers to “the effective level of cooperation” (Stivers et al., 2011, p.20), indicating that both parties are cooperative, in agreement with the prior action, and share evaluative and affected stance. In other words, Stivers et al. (2011) asserted that affiliative responses are considered as the “effective level of cooperation,” meaning that “they are maximally pro-social when they match the prior speaker’s evaluative stance, display empathy and/or cooperate with preference of the prior action” (p. 21). By using affiliative responses, the recipient demonstrates that his/her stance is similar to the speaker’s evaluative stance, thus supporting what is being reported as, for example, funny, horrible, or thrilling (Stivers, 2008, p. 35). According to the authors, affiliation is not always applicable or appropriate. For instance, it might be difficult to affiliate with a stranger’s request for information, such as “Where do you live?” or “How much do you earn?”<sup>66</sup>

Viewed from this perspective, *affiliation* can be said to be concerned with social level (i.e. action level), whereas *alignment* works on the structural level (i.e. formal level). Steensig (2013) made a clear distinction between alignment and affiliation, as shown in Table 11.

**Table 11.** Overview of alignment and affiliation features

<i>Alignment: structural level</i>	<i>Affiliation: effective level</i>
Facilitate and support activity or sequence	Display empathy
Take proposed interactional roles	Match, support, and endorse stance
Accept presuppositions and terms	Cooperate with action preference
Match formal design preference	

Source: Steensig (2013, p. 1)

Thus, alignment and affiliation work in structurally organised actions and are more relevant than, for example, disaffiliation and misalignment are. This implies that participants’ actions may make alignment and affiliation highly relevant in the

<sup>66</sup> My examples

response. The following extract<sup>67</sup> shows how alignment and affiliation work during three-party medical interactions.

**Extract 6.1. (H3 V61 D23 Da. 7/1/2012. Cl. Haem. ) (Pt: aged 50; her daughter: aged 25)<sup>68</sup>**

- 97 Dr1: =ya ni ma bta khdhi sh ala u l il bta <sup>3</sup>ghuda?<sup>69</sup>  
98 Pt: la ma a khudh kul ala u l, habitli iltiha b.  
99 Dr1: ma hwwa hwwa bta > <sup>3</sup>ghuda da ma bi milsh iltiha b wala,  
100 a ga <ka n bta khdi minu haba t, =  
101 Pt: = iggi r i h.  
102 Dr1: → iggi r? illi hi a ka n khamsa w ishri n micru gram illi bitakhadhiha?  
103 Pt: → i wah.  
104 F.CH: →i wah i wah.

- 97 Dr1: =you don't constantly take the drug for your glands?  
98 Pt: No I don't take it constantly; it gave me a burning sensation.  
99 Dr1: The one which is for >glands doesn't cause any burning nor,  
100 anything else <did you used to take a tablet? =  
101 Pt: =a small one yes.  
102 Dr1:→ Small? Twenty-five milligrams?  
103 Pt: → Yeah.  
104 F.CH: →Yeah yeah.

In the above extract, the doctor seeks confirmation from the patient regarding the quantity of the medicine she takes, “Small? Twenty-five milligrams?” as shown in line 102. In response to this, the patient confirms by using “yeah” (line 103). In terms of alignment, the patient’s use of “yeah” aligns with the doctor’s request in line 102, which indicates that she accepts her interactional role as a recipient and at the same time supports the progress of sequential interaction. In terms of affiliation, the patient’s chaperone affiliates and adopts the stance of alignment with the patient by supporting the patient’s agenda, thus forming a cooperative response. Therefore, the chaperone’s response is both aligning and affiliating. In terms of alignment, the chaperone’s response is congruent with the patient’s position in that they have epistemic access to the state of affairs. This confirmation agreement is thus affiliative and aligning.

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<sup>67</sup> All the examples presented in this chapter are from my own data.

<sup>68</sup> (See Appendix 9 for a list of abbreviations and Appendix 10 for a list of transcription conventions).

<sup>69</sup> (See Appendix 11 for the IJMES transliteration system of Arabic consonants and vowels).



However, in social interactions, misaligning behaviour can be disaffiliated. In other words, recipients sometimes misalign and at the same time disaffiliate with speakers. In the following excerpt, the doctor seeks input from the patient in order to ascertain whether she has any complaints. The chaperone, rather than the patient, responds to the doctor's question, as shown in line 27.

**Extract 6.2. (H3 V2 D2 Da. 10/12/2011. Cl. Radio-th. ) (Pt: aged 35; her husband: aged 49)**

26 Dr1: → tishtiki n min shai ?  
 27 M.CH: → >laa↑ nisi na ³mu id ya duktu r liduktu r ³aw i a ad-damawi a<  
 28 Dr1: li h kida ?  
 29 M.CH: °erm° nisi na wa fa t ali na ³maw id.

-----  
 26 Dr1: → Do you have any complaints?  
 27 M. CH: → >No↑ we missed the appointment with the vascular surgeon <  
 28 Dr1: Why?  
 29 M.CH: °erm° we forgot and we missed the appointment.

The doctor's turn as a "*B-event statement*" (Labov & Fanshel, 1977, p. 100)<sup>70</sup> implements the practice of selecting the patient to respond next by using the pronoun "you." In response to that prompt, even though her husband has neither the right nor obligation to respond, he nonetheless adopts the position of authority and responds to the physician's question. This behaviour violates the rules of turn-taking, as well as constructs a particular identity for the chaperone as a dominant actor in the triad (Robinson, 2007) (see Chapter 7 for more details). In other words, the male chaperone's response in line 27 "No↑we missed the appointment doctor with the vascular surgeon" is an obvious misalignment, while also demonstrating disaffiliation. With regards to misalignment, in a quick response, the patient's husband took the turn that is directed at the patient in order to initiate a different action. This attitude is considered as a kind of misalignment, aimed at impeding the patient's progress in the conversation. The chaperone's disaffiliated response not only prohibits the patient

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<sup>70</sup> A *B-event statement* means statement addressed by the physician who lacks knowledge about patient's concerns (patient's complaints) in which patient has epistemic access to the information about his/her illness (see Chapter 7).

from responding but also does not give the patient the opportunity to confirm whether or not she has any complaints (see Chapter 7).

To sum up, alignment and affiliation are forms of cooperation in social interaction. Aligning responses maintain the structural organisation of the interaction. In contrast, affiliative actions are only made relevant after utterances that endorse the teller's stance or show a preference for a specific action. Both alignment and affiliation have strong links with norms of knowledge (Stivers, et al., 2011) (see Chapter 7). Participants' adherence and enforcement with these norms in social interactions cooperate by moving the sequence forward in logically ordered actions that affect the participants' social relationship. These organised actions along with participants' positioning vis-à-vis each other represent various forms of alignment. Any violation of these organised actions and norms leads to misalignment and disaffiliation.

### **6.2.2. Forms of alignment**

There are three forms of alignment governed by knowledge norms (see Chapter 7). These are: (1) confirmation (by 'yeah' and by repetition), (2) expansion, and (3) turn completion. Each is discussed below with reference to prior studies of Conversation Analysis.

#### **6.2.2.1. Confirmation through the alignment token 'yeah'**

The Conversation Analysis (CA) literature on knowledge in interaction focuses on confirmation sequences (Heritage & Raymond, 2012; Schegloff, 1996; Stivers, 2001; 2005). Conversation analysts negotiate the differential distribution of rights and responsibilities with respect to knowledge among participants in interactions (Heritage & Raymond, 2005; Sidenel, 2012; Stivers, 2005; Stivers et al., 2011). According to Sidnell (2012), the confirmation sequence consists of two positions, e.g. a question and answer. In the confirmation sequence, agreement or disagreement depends on 'who knows better' or 'who knows best' (Sidnell, 2012, p. 309). One of the main features of the confirmation sequence is epistemic access. This means that in order to confirm or disconfirm the previous utterance, the respondent should have epistemic access to the subject on which they are being asked to comment. The most common response to the confirmation question is *yeah*. Consequently, the appearance of *yeah*

in order to confirm the prior turn has a significant impact on the participant's understanding and the way it is reflected in the following conversation (Sidnell, 2012).

In seeking confirmation from a recipient, the answer should be provided by the selected next speaker only if he/she was addressed in the prior turn (Heritage, 1984a). For example, in directing the question at the patient, the doctor indicates that the patient is a competent informant who is capable of answering and has the primary right to answer (Clemente, 2009). In other words, the physician's confirmation question is designed in line with what Labov and Fanshel (1977) called "*a b-event statement*" (p. 100). Therefore, by confirming a state of affairs, this means that the recipient (i.e. patient) confirms factual claims. In the following example from three-party medical interactions, confirmation is done through the alignment token 'yeah'.

**Extract 6.3. (H3 V12 D8 Da. 18/12/2011. Cl. Sur. Onc.) (Pt: aged 45; her sister: aged 30)**

55 Dr1.	→	bitakhadi li l q <sup>3</sup> sukar bintizam?
56 Pt.	→	i_wah.
57 F. CH	→	i_wah (.) i_wah.
-----		
55 Dr1.	→	Do you take drug for diabetes regularly?
56 Pt.	→	Yeah.
57 F.CH	→	Yeah (.) yeah.

Confirmation with 'yeah' is not the only form of alignment but repeating the speaker's prior turn either partially or completely is another type of alignment as well.

#### **6.2.2.1.1. Confirmation by repetition**

The most important form of confirmation that is similar to the "yes" or "no" confirmation-type is repetition (Lee, 2015; Schegloff, 1996; Stivers, 2005; Stivers, et al., 2011). Stivers (2005) mentioned different ways that participants use to confirm the speaker's previous turn, one of which is repetition. Repetition is a practice that is used to establish agreement with the prior turn by reiterating it either fully or partially. Therefore, repeated responses tend to add more confirmation rather than affirmation on the proposition raised by the interrogator (Schegloff, 1996). In addition, they claim greater epistemic rights over the information required than the original polar question conceded (Heritage & Raymond, 2012). Also, repeat-formatted answers claim greater

epistemic authority and entitlement regarding the matter being negotiated than do token answers (Sidnell, 2012). Heritage and Raymond (2012) showed the difference between yes/no confirmational and repetitional responses, noting “We may conclude that repetitions exert more agentive leverage on the terms of the questions to which they respond than type-conforming yes/no responses thereby constituting a basis in practice for a wide range of actions” (p. 12). An example of confirmation by repetition is presented in Extract 6.4 below.

**Extract 6.4. (H3 V8 D5 Da. 13/12/2011. Cl. Sur. Onc.) (Pt: aged 32; her husband: aged 40)**

- 15 Dr1: → mata sawi ti ashi a at-tilfizyu ni a?  
16 Pt: → gabl usbu i n.  
17 M.CH: → gabl usbu i n.  
18 Dr1: → gabl usbu i n?  
19 Pt: → i\_wah.

- 15 Dr1: → When did you have the ultrasound?  
16 Pt: → Two weeks ago.  
17 M.CH: → Two weeks ago.  
18 Dr1: → Two weeks ago?  
19 Pt: → Yeah.

Sometimes confirming either by yeah or repetition is insufficient and the next speaker needs to expand and clarify the prior turn as seen below.

### 6.2.2.2. Alignment through expansion

Expansion, according to Stivers and Heritage (2001), is designed to address possibly problematic issues or features in a patient’s minimal responses. In three-party medical interactions, expanded responses tend to occur when the patient has difficulty in giving precise answers to some questions and when chaperones find that the patient’s responses are insufficient. Consequently, the chaperones feel the need to support the patient’s answers by adding more supporting details and clarification (Stivers & Heritage, 2001). In these expansions, the chaperone facilitates the physician’s understanding by providing him with some degree of access to the patient’s symptoms based on his/her observation (see Chapter 7). The function of the chaperone’s additional or elaborated responses enhances the objectivity and credibility

of what he/she observes concerning the patient's illness (Stivers & Heritage, 2001). An example of expansion from three-party clinics is displayed below.

**Extract 6.5. (H3 V8 D13 Da. 18/12/2011. Cl. Chemo) (Pt: aged 70; her daughter (40) and son (37))**

40 Dr1. → bas ti asi ba alam fi dhi ra k<sup>3</sup>ilaysar?

41 Pt. → i wah.

42 F.ch. → wa yida nha kama n.  
-----

40 Dr1. → Do you feel pain in your left arm?

41 Pt. → Yeah.

42 F.ch. → And in both her hands as well.

If the participant (i.e. the chaperone) shares some epistemic access of another participant's (i.e. the patient's) health problem, it is, therefore, possible for the next speaker to complete the previous speaker's turn as explained in the following section.

### **6.2.2.3. Alignment through turn completion**

Turn-completion is locally managed and interactionally implemented through the system of turn-taking (Lerner, 2004; Sacks et al., 1974). In the turn-taking system, the completion of a turn constructional unit (henceforth referred to as TCU) can be either an actual completion carried out by the original speaker or a transition to a newly selected speaker (Lerner, 2004). For example, in an adjacency pair, when the first pair-part (e.g. question) of the adjacency involves a TCU, this unit is likely to be the final TCU that the speaker uses before the speaker transition (Lerner, 2004). It is possible for the next available participant (other than the original speaker) to then produce a completion of the turn. Therefore, the next available speaker has two options: either to initiate a new TCU or complete the one that is available for possible completion (Lerner, 2004; Sacks et al., 1974). The purpose of these constraints in turn organisation is to maintain the continuity and progressivity of the first (i.e. question) and second (i.e. answer) pair-parts of the sequence (Sacks et al., 1974; Sacks, 1987). The appropriate completion of some parts of the prior speaker's action/TCU demonstrates some form of understanding or alignment by the co-participants. It is then the responsibility of the original speaker, who has the primary authority to claim

knowledge, to validate or assess the acceptability of the proposed completion (Lerner, 2004) as shown in the following example.

**Extract 6.6.<sup>71</sup> (H3 V8 D13 Da. 18/12/2011. Cl. Chemo) (Pt: aged 70; her daughter (40) and son (37))**

55 Dr1:                    mashya takhdi    abayyat min  
 56                    →                    ³birsham alli di ka ki ?  
 57 Pt:                    →                    abati n=  
 58 F.ch:                →                    = abah fi ³ywam wa dah fi ³liyal.  
 59 Pt.                    abah fi ³ywam wa dah fi ³liyal.

-----  
 55 D1:                    Are you still taking the tablets  
 56                    →                    that we've prescribed?  
 57 Pt:                    →                    Two tablets =  
 58 F.ch                →                    =one during the day and one at night.  
 59 Pt.                    One during the day and one at night.

In summary, the three forms of alignment discussed above (i.e. confirmation, expansion, and turn completion) with reference to some examples of three-party interactions share common features. First, participants accept the norms of turn-taking. Second, chaperones share some epistemic access to the patient's health problems which enable him/her to align and affiliate with the patient's prior turn. Third, accepting the social norms as well as the chaperone's active role facilitates the sequence of the upcoming sequence of organised actions in order to achieve the goal of the visit.

To understand further how alignment works in actual three-party consultations, the following section discusses prior conversation analysis research in this field.

**6.2.3. Alignment in medical conversation analysis studies**

While third-party alignment has received considerable attention in sociological and medical studies (see Chapter 2), Conversation Analysis (henceforth referred to as CA) studies rarely focus specifically on the organisation of three-party alignment in medical interactions. In three-party interactions, alignment has been investigated in paediatric (Clemente, 2009; Stivers, 2001), oncology (Korfage et al., (2013), and

<sup>71</sup> This extract is continued from Extract 6.5.

emergency (Lee & Kim, 2015) departments. Moreover, these studies were conducted in the US and Korea (Lee & Kim, 2015). A summary of adult three-part studies is provided below.

Korfage et al., (2013) conducted their study in two hospitals located in the south-west of England and applied CA to explore how a chaperone's presence in an oncology consultation regarding palliative chemotherapy contributes to the communication process and decision-making. Patients with advanced non-small cell lung, pancreatic, or colorectal cancer were recruited to explore their experiences of decision-making and treatment regarding palliative chemotherapy. The study sample comprised of forty-five patients with advanced cancer, most of whom were elderly, (21 male and 18 female patients). Three patterns of alignment were identified, namely (1) chaperone-patient alignment, (2) chaperone-physician alignment (where the chaperone mainly provided more information about the patient), and (3) physician-patient-chaperone (all of whom interacted during the medical visit). Chaperone-patient alignment occurred when the chaperone discussed the information received and checked the patient's understanding of treatment preferences. In chaperone-physician alignment, the chaperone was present throughout the consultation and aimed to provide more information about the patient. Finally, physician-patient-chaperone alignment occurred when the physician gave the patient advice regarding the treatment plan. In this case, the patient aligned with the chaperone to ask his/her opinion regarding the physician's palliative chemotherapy as a treatment option, which was accepted by the patient. If the chaperone did not offer his/her opinion, the physician joined in to assure the patient that he/she could stop the therapy at any time. Although the authors applied CA, they did not show the process of alignment formation in triadic interactions. In addition, they did not elaborate on the practices the participants used to form the aforementioned alignments.

Lee and Kim (2015) examined different interactional patterns in presenting patients' problems, both whether the presentation was made by the patients themselves or by their chaperones on behalf of the patient. The data for the study was gathered by the video recording of actual, routine triage interactions in an academic emergency department at a tertiary teaching hospital in Seoul, Korea. The analyses were based on 242 video-recordings of triage interactions between nurses and patients and/or their

chaperones. The authors identified two types of alignment, namely (1) nurse-patient alignment, and (2) nurse-chaperone alignment. Nurse-patient alignment occurred in response to the nurse's question soliciting a single reason for a visit, mostly in the form of "where does it hurt so that you came?" (p, 578). This form of question is designed to ask for the location (where) of the pain or a problem. In response, patients tended to be succinct and provide simple descriptions, by using a general term referring to pain ("hurt") and its location, such as "stomach hurts." In chaperone-nurse alignment, the chaperone aligned with the nurse in order to present the patient's complaints. This information was usually given in the context of what the patient said. For example, the chaperone would commence with "he says" and provide further information, such as other current symptoms and medical history.

A study carried out by Bolden (2000) examined the role of medical interpreters in structuring interactions between physicians and their patients during the history-taking part of medical consultations. The data was sourced from a corpus of video-recorded and audio-recorded interpreter-mediated consultations between English-speaking doctors and Russian-speaking patients in the mid-western part of the US. The author examined the ways in which interpreters' actions were structured by the roles they adopted within the interaction and how these roles fit into the overall organisation of the activity. Bolden noted that, in patient-interpreter alignment, the patient aligned with the interpreter by using minimal tokens, such as "yes," by expanding on the interpreter's question, or by turn completion. The study findings further revealed that interpreters' actions were typically organised towards the goal of the history-taking activity, i.e. they aimed to collect information that is diagnostically relevant. In the interpreter-doctor alignment, the interpreter provided/offered a summary translation to the doctor, reporting only information related to medical contingencies, while leaving out any information deemed irrelevant. Additionally, patient's experiential accounts tended to be excluded from the summary translation, even if diagnostically relevant.

When interpreting these findings, some critical issues should be noted. First, the findings yielded by the existing CA research on alignment in three-party interactions in medical settings are somewhat difficult to interpret. Researchers did not explain how linguistic resources (e.g., confirmation, and turn completion) help interlocutors to



align and affiliate with one another. Second, although alignment in three-party medical interactions is valuable in obtaining a full or general understanding about patient participation and chaperone roles, these studies provide only a limited insight into what happens during real life medical encounters. Therefore, this research is an attempt to fill this gap in our understanding of alignment practices by means of a close analysis of actual physician-adult patient-chaperone consultations in Saudi Arabia, an area that has not been investigated before. Thus, the present study aims to answer the following research questions:

**How does alignment occur in three-party interactions and do chaperones' alignments vary according to their gender?**

To answer the above-mentioned questions, CA was followed to analyse the audio-recorded data as described below.

### **6.3. Data Analysis Methodology**

To answer the third research question in this thesis regarding how alignment occurs in three-party interactions, audio-recording of three-party medical consultations was required (see Chapter 3). To analyse the audio-recorded data, CA was chosen for different reasons: (1) to reveal the recurring patterns of alignment which participants used to construct their activities, (2) to examine the sequential organisation of alignment in three-party interactions, (3) to uncover the underlying norms of alignment in social interactions (e.g. distribution of rights to speak) and how participants develop mutual understanding. In the following section, a summary of a CA framework is presented as well as the steps followed in analysing the audio-recorded data.

#### **6.3.1. Conversation analysis**

Conversation Analysis (henceforth referred to as CA) was first introduced by the pioneering sociologists Harvey Sacks and Emanuel Schegloff in the early 1960s, whereby they examined the orderliness of social interaction. As a qualitative analytical approach to social interaction (Hutchby & Woofitt, 1988; ten Have, 1999), CA aims to study “the order/organisation/orderliness of social actions, particularly

those social actions that are located in every day interaction, in discursive practices, and in the sayings/telling/doings of members of society” (Psathas, 1995, p. 2). As an approach to examine the organisation of particular social actions, CA emerged from a branch of sociology called ethnomethodology which was developed by Garfinkel (1964, 1967), and studies practices through which the participants develop mutual understanding and create orderliness in their social interactions. As an interdisciplinary approach, CA has been used to examine institutional speech in different settings, such as courtrooms (Atkinson & Drew, 1979), classrooms (McHoul, 1978; Seedhouse, 2004), and medical consultations (Stivers, 2001, Stivers & Heritage, 2001), in order to uncover the underlying rules and assumptions of speech in interaction.

The first assumption of CA is that speech is understood as a social action, i.e. it is what interlocutors do while talking. Therefore, what participants say or do—including non-verbal interactions—is regarded as performing social action. These actions can be connected with other activities; for instance, in medical consultations, this may include taking patients’ illness histories and conducting patient examinations (Chatwin, 2008). Conversation analysts are not only concerned with participants’ acts but also how their acts are organised, as seen in the following assumption (Garfinkel, 1967).

The second assumption of CA is that speech is sequentially and structurally organised. This means that the analyst aims to observe the structural level and flow of speech. For example, adjacency pairs, as a part of turn-taking, are considered as the automatic sequence and vital factor for the flow of interaction. The fundamental element of CA is turn-taking, which is perceived as the main resource for the construction of mutual understanding among participants in interaction (Heritage, 1997). Therefore, when a turn in a conversation occurs, it is simply a response to the preceding turn. However, if the participant fails to respond to the previous turn or someone takes the turn of the selected speaker, a conversational disrupt will be created. The conversation analyst’s task is to observe and examine the sequential organisation of interaction, such as turn-taking (including the distribution of speaking rights) and the organisation of adjacency pairs (such as history-taking questions and answers). According to Heritage (1984a), participant’s contribution to action is context-shaped and context-renewing. The speaker’s action, when viewed as context-shaped, refers

to the mutual understanding between the speakers, therefore, the speaker's conversational contribution is shaped by what he/she understood from the preceding turn. At the same time, speech is context-renewing, as it is shaping the context, given that each element of conversation affects what follows (e.g. diagnoses and treatment). In this case, the context of the next action is renewed with each current action (Maynard & Heritage, 2005). In summary, the sequential occurrence of orderly actions forms conversational practice.

Conversational practice—as the third assumption of CA—refers to the recurring patterns (i.e. activities/acts) of the observed sequence, which participants use to construct their activities (Heritage, 1997). Such recursive patterns of sequence can be used by different participants in different contexts for different purposes. Therefore, the sequential practice is an important feature of CA, as it helps to analyse three-party medical interactions in order to uncover the norms of medical interaction and the deviant cases (see Chapter 7).

The fourth assumption of CA is that participants' actions create and maintain intersubjectivity (Heritage, 1984a) of whether or not their actions are normatively appropriate conduct. Intersubjectivity implies shared understanding of the prior action between the participants. Consequently, failure to respond to the prior action is considered “an observable and reportable deviation” (Heritage, 1984a, p. 116) from the normal conduct. The shared understanding of actions is governed by a variety of social norms for analysing actions-in-context (Garfinkel, 1967). These norms serve as a “grid” (Heritage, 1984a, p. 117) for organising each other's social actions.

Investigating these norms from the CA perspective, with reference to alignment in three-party interactions, reveals the mutual accountability and orientation to these norms, which form communicative and coherent understanding among participants. On the other hand, the absence of these norms reveals cultural breaches of patient autonomy (see Chapter 7). In the points that follow, I discuss some criticisms which have been made of CA in previous research.

#### **6.3.1.1. The Limitations of conversation analysis**

As mentioned above, Conversation Analysis (henceforth referred to as CA) is a highly distinctive method for examining social interactions. It is characterised by its

naturalistic data collection, orderliness of social action, and the underlying structural norms that govern the organisation of social actions. However, CA has been criticised for analysts' interpretation of the recorded data. This criticism is briefly discussed below, along with the respective response.

CA has attracted some criticism with respect to the analysts' ability to accurately interpret the participants' actions/acts (Billig, 1999a, 1999b; Hammersley, 2003). Billig (1999a) and Hammersley (2003) argued that CA analysts could interpret the data differently from the participants themselves. However, in making this assumption, both authors reveal their misunderstanding of the CA methodological approach (Wooffitt, 2005). CA analysts should analyse the data without bringing any *a priori* theories into the process or taking things for granted. Moreover, they should discover the visible order not through participants' own words but through the actions or acts that are demonstrably relevant to the participants themselves. What strengthens the validity of CA is that on presenting some of my data extracts in data sessions at both SEDIT and at Loughborough University (see 6.3.3.4 Collaborative observation), the same conclusion was reached although both sessions were attended by different researchers.

CA was used in this study in order to provide additional insight and a better understanding of the chaperone's efforts exerted during the medical visit, either positively or negatively. Thus, CA could assist in improving the physician-patient relationship.

In the next section, an overview of how a medical setting for institutional talk is used to complement CA is discussed.

### **6.3.2. A conversational analytic approach to medical consultations as institutional talk**

The extant studies employing CA have been conducted in diverse healthcare provider-patient settings (Clemente, 2009; Lee & Kim, 2015; Stivers, 2001), whereby CA analysts have investigated specific aspects of the medical environment to uncover the underlying rules that govern how actions are organised. Used in this context, CA allows the examination of the operation of social institutional interaction in a medical setting. Medical interaction is one of the key areas of institutional talk that have been

investigated in extant CA research (Heritage & Maynard, 2006; Stivers, 2001). Even though three-party medical interaction is an important example of institutional talk, it has not been thoroughly studied by conversation analysts. According to Heritage (2004), medical interaction has three main characteristics of institutional talk. The first feature is that medical interaction involves goals that are connected to institution relevant identities. That is the goal is that patients present their medical problem and the doctor conducts a diagnosis upon which a treatment will be given. The second states that medical interaction involves particular constraints on what is allowable with respect to these goals. For example, a chaperone taking the patient's turn when the patient is addressed and capable of speaking, or a doctor asking the chaperone rather than the patient about the patient's problem would be deviating from the turn-taking norms. The third feature states that medical interaction involves special inferences that are particular to three-party interactions. For example, in a medical interaction, the chaperone may be expected to perform the advocate and facilitator roles (by facilitating the patient's and doctor's understanding). Likewise, inferences might be drawn from the doctor's questions which are directed at the patient to display relevant knowledge about her illness.

In analysing medical interactions, the analyst has to take into consideration that the institution or setting does not form the interaction. Rather, it is through participants who "build the context of their talk in and through their talk" (Heritage, 2004, p. 109) that the interaction can be discerned. According to Heritage (2004), context "is both a project and a product of the participants' actions" (p. 109). Importantly, participants build and manage the context through their actions and acts (Heritage, 2004). Medical setting is characterized by its specialized turn-taking system, which forms the distinctive overall structural organisation.

Institutional talk is distinctive from mundane conversation. It has been shown to exhibit five different features of interaction: (1) turn-taking organisation, (2) sequence organisation, (3) turn design (design of turns); (4) lexical choice (choice of specific words or phrases), and (5) overall structural organisation (opening and closing). In the context of three-party interactions, the first four aspects have been examined in extant literature (Clemente, 2009; Stivers, 2001) as well as analysed in the current research.

To conduct the CA of audio-recorded data, a systematic step-by-step guide was followed, as described below.

### **6.3.3. Steps in analysing the audio-recorded data**

As already mentioned in Chapter 3, I collected 117 medical recordings from 20 clinics in three hospitals in Jeddah. The majority of these recordings came from the governmental hospital, which totalled about 120 hours of data. In contrast with the methodology of Chapter 5 in which the data was four open-ended questions that asked the patients to write their experiences regarding their chaperones' presence during their medical appointments, in this chapter the data methodology depended on the recording of naturally occurring three-party medical interactions. Each data, in both chapters, has a specific data management method of analysis different from the other. This means that the written data in Chapter 5 required a thematic analysis framework whereas in the current chapter conversation analysis methodology was used for the recorded data. In preparing the audio-recorded data for conversation analysis, there are certain steps that should be followed in order to study the recurrent patterns in medical interaction. In this section, I will describe step-by-step how I undertook a CA of audio-recorded data on three-party medical interactions.

#### **6.3.3.1. Organising the audio-recorded data**

Following the recommendations of conversation analysts (Psathas & Anderson, 1990; ten Have, 1999), in how to construct transcript files, the data was first prepared for the analysis by organising and storing the 120 hours of audio-recorded material. For this purpose, a coding system was used, including the hospital number in which the original recording took place (e.g. H3), the visit number (e.g. V37), the day of the recording (e.g. D37), the date of the visit and the recording (e.g. Da. 1.12/2012), and the clinic type (e.g. Cl. Chemo-th means the Chemotherapy Clinic). To exemplify, an extract classified as 'Extract 3: H3V3D3Da.1.1.2012Cl.Chemo-th' indicates that this is the third extract that was taken from the Chemotherapy Clinic on 1st January 2012, recorded on the third day from voice file three of the third hospital. A detailed list of the audio-recorded files can be found in Appendix 17.

### 6.3.3.2. Transcribing the data

The second step of the CA process was to transcribe the audio-recorded data. Heath and Luff (1993) argued that transcription provides the analysts with a clear picture of participants' activities and a way of identifying any interesting phenomena that might help the analyst to focus purely on their socio-interactional organisation. Therefore, the majority of the data was transcribed in full,<sup>72</sup> whereby the selected sequences were fully transcribed<sup>73</sup> using a playback foot pedal machine along with headphones. This allowed the transcriber to repeatedly listen to the fragments of speech, control the tape recorder, and immediately type the transcription in a word document.<sup>74</sup> In addition, field notes, which were taken during each clinical observation, were of great importance in determining when the three parties engaged in interaction or when a third person or a patient was a silent observer or sometimes excluded from the talk. In transcribing the three-party interactions (see Appendix 18 for all the transcripts of three-party medical interactions presented in this thesis), a fixed layout was adopted, as follows. Each line was numbered at the left-hand margin and plenty of space was left between the speakers' initials and their utterances. An identification code at the beginning of the turn was used to indicate who was speaking (e.g. Dr: for doctor, Pt: for patient, F.Ch: for female chaperone, and M. Ch: for male chaperone, [see abbreviated forms in Appendix 9]). Participants' names have been changed to preserve their identity (see Ethical Considerations in Chapter 3). Moreover, transcription conventions for the audio-recorded data—in this thesis—were mainly based on the transcript system developed by Gail Jefferson (1985, 2004) (see Appendix 10) and are extensively used by conversation analysts (Heritage & Atkinson, 1984; Heritage & Maynard, 2006; Ten Have & Psathas, 1995).

As almost all the recorded medical interactions took place in Arabic,<sup>75</sup> and a transliteration system for Arabic was used, based on the *International Journal of Middle East Studies* (IJMES) (see Appendix 11), which is widely used in Middle Eastern and Islamic research. In addition, in translating the Arabic data into the

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<sup>72</sup> A paid transcriber was employed.

<sup>73</sup> The selected sequences were also revised by the researcher.

<sup>74</sup> In each Word document, I included the following information: name of the clinic, visit number, duration of audio recording, patient's number, chaperone type, relation to the patient, visit type, patient's medical case, and the attendees.

<sup>75</sup> Sometimes, interactions between two or more doctors are conducted in English.

language of this thesis (English), the English translation, rather than the literal one, is provided below the transliterated text (Liddicoat, 2007; ten Have, 1999). In addition, transcription conventions are marked in both the transliterated Arabic as well as the translated English texts.

### **6.3.3.3. Listening repeatedly to the data**

Once the audio-recorded data was transcribed, the researcher focused on listening repeatedly to the audio-recordings alongside the transcripts to check and revise the content, as recommended by CA practitioners (Liddicoat, 2007; ten Have, 1999). The aim of this process was to identify and describe the recurrent practices of three-party medical interactions that form the building blocks of the study (Sidnell, 2013). To do this, I followed the basic analytic techniques through different stages, as recommended by conversation analysts (Hutchby & Wooffitt, 1998; Pomerantz & Fehr, 1997; Sidnell, 2013; ten Have, 1999). In the first stage, I started with preliminary observations, noting some distinctive parts of speech or a sequence in a medical interaction through the process of “unmotivated looking” (Schenkein, 1978, p. 1-6). In this context, the term “unmotivated looking” implies that the analyst should not bring any assumptions or theories to the phenomena arising from the data itself (Hutchby & Woffitt, 1998; Psathas, 1995; Sacks, 1984b). The goal of preliminary individual observation is to identify any recurrent interesting patterns that might be used “to generate a search procedure” (Sidnell, 2013, p. 88). Collaborative observation is also recommended by many CA researchers (Sidnell, 2013; ten Have, 1999) as discussed below.

### **6.3.3.4. Collaborative observation**

With respect to collaborative observation, I presented some transcripts from my data in two data sessions, namely, SEDIT,<sup>76</sup> held at the Psychology Building, George Square, Edinburgh University, and a three-day long training workshop at Loughborough University. Both sessions were attended and observed by different researchers from different projects, along with experienced discourse and CA analysts.

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<sup>76</sup> Scottish Ethnomethodology, Discourse, Interaction & Talk (Group).



Such sessions were extremely helpful in identifying analytical themes and negotiating interesting extracts. Such collaborative observations and discussions are beneficial in several ways. First, participating in data sessions is an excellent opportunity for novice researchers to meet with more experienced CA analysts and colleagues from different backgrounds (ten Have, 1999). Second, collaborative viewing provides the researchers with “brainstorming” materials (Chatwin, 2004, p. 133), as different researchers notice different data features, which plays an important part in the analytic process. Thus, such discussions promote the presenter’s understanding of his/her own data (Sidnell, 2013; ten Have, 1999). Third, in a collaborative group, when observing some extracts, the researchers avoid “neutralizing preconceived notions” (Jordan & Henderson, 1995, p. 44). As a result of personal and collaborative observations, the conclusion regarding the emergence of some of the recurrent patterns in my data gained from SEDIT or data sessions at Loughborough University was the same, although different researchers were involved. Reaching the same conclusion from different researchers defends CA against the criticism raised by Billig (199a) and Hammersley (2003) (see 6.3.1.1) on the one hand and enhances the reliability of the data analysis level (Stahl, 2009) on the other.

During the data analysis process, interactional practices of alignment and knowledge asymmetry (see Chapter 7) in three-party medical interactions were identified. In terms of alignment, three recurrent patterns of alignment were identified, namely (1) doctor-patient, (2) chaperone-patient (and patient-chaperone), and (3) chaperone-doctor (and chaperone-patient) alignments. Both patterns were marked in the margins of transcripts and inserted into three different MS Windows files, designated for the three types of above-mentioned alignments. During this process, I also aimed to establish how alignment is developed and what participants are doing. This led me to identify a sequence of actions in three identified patterns and allowed me to mark its boundaries. In addition, I focused on the *adjacency pairs/question-answer sequence*, i.e. how the doctor initiated an action and how the patient and chaperone responded (see the results in this chapter). I also focused on the *turn-taking system* (Sacks, et al., 1974), i.e. I aimed to ascertain what happened in the previous turn and the subsequent one. In other words, I focused on the alignment turn, i.e. those turns in the conversation that are relevant in ensuring understanding and alignment of

co-participants (Lerner, 2004). I concentrated on the ways in which participants jointly construct alignment and how the participants are in a close and “balanced alignment” (Chatwin, 2008, p. 113).

During this process, I observed how alignment (e.g. doctor-patient, chaperone-patient, and patient-chaperone) was developed and achieved through structurally organised actions. These actions represent a set of norms which are strongly related to participants’ understandings of these norms. Therefore, I began analysing individual cases of three types of alignment, while searching for further examples to expand my analysis and see if any counter-examples could be found. Once the collection of relevant instances was completed, I started describing and analysing the clearest and the most visible cases of alignment in the context of a recurrent sequence of actions. For example, *chaperone-patient and patient-chaperone alignment* was the most noticeable pattern in the recorded data, and consisted of four sequential actions, namely (1) *the doctor’s medical question directed to the patient*, (2) *the patient’s response*, (3) *the chaperone’s expansion on the patient’s answer*, and (4) *the patient’s confirmation*, (see the results below in 6.4). In addition, for the third pattern, i.e. chaperone-doctor and chaperone-patient alignment, the sequential actions that emerged are: (1) *the doctor’s medical question directed to the patient*, (2) *the patient’s response*, (3) *the doctor’s recommendation*, (4) *the chaperone’s repetition of what the doctor has just said*, (5) *the patient’s confirmation*. The emergence of the three above mentioned patterns helped to answer the second section of the third research question in this thesis regarding gender variation (i.e. do chaperones’ alignments vary according to chaperone gender?).

Gender variation was determined through the three identified patterns of alignment, although looking at the gender of the participant this way would be against the CA assumptions in that the interlocutor’s social identity is only made relevant in the interaction. The rationale for investigating gender variation outside the limits of CA is twofold: (1) to give a complete picture of triadic medical interaction in Saudi Arabia and (2) to be consistent with the previous chapters (4 & 5) that examine the effect of age, education, and gender on patient satisfaction with chaperone involvement. Therefore, two procedures were followed in determining gender variation. The first was to count the frequency of alignment types in each consultation

separately, and the second was to identify the total number of instances across the data between male and female chaperones. Once the gender variation was identified, two tables for each pattern ([1] doctor-patient and chaperone-patient alignment; and [2] doctor-patient and chaperone-doctor alignment) were created: one for examining the frequency of alignment in each consultation and the second to count the instances of alignment (i.e. chaperone-patient and chaperone-doctor alignment) between male and female chaperones across the data (see 6.4).

In the following section, I present the results of the CA analysis of the third research question in this thesis.

#### **6.4. Conversation Analysis Results**

In this section, I discuss the results of the third research questions of this thesis. To review, the research questions were:

**How does alignment occur in three-party interactions and do chaperones' alignments vary according to chaperone gender?**

The results of the above research questions have been presented in two parts. The first discussed the different types of alignment that took place during the medical visit among the three parties. The second discussed gender variation of alignment.

##### **6.4.1. Types of alignment in three-party interactions**

Three types of alignment emerged from the data, namely (1) doctor-patient alignment, (2) chaperone-patient alignment and (2) doctor-chaperone alignment. Each will be discussed in turn with reference to some extracts from the data.

###### **6.4.1.1. Doctor-patient alignment**

When doctors name a patient using a term of address (e.g. Fatma) or the second person pronoun, 'you', to seek more information or confirmation, the patient aligns with the doctor by providing him/her with the requested information. This type of alignment is recurrent in the second (i.e. chaperone-patient) and the third (i.e. doctor-chaperone) type of alignments. The second type of alignment, namely, chaperone-

patient and patient-chaperone alignment is discussed below with reference to doctor-patient alignment.

#### 6.4.1.2. Chaperone-patient and patient-chaperone alignment

As mentioned above, when the patient aligns with the doctor to confirm a certain state of affairs, in this case, the chaperone aligns with the patient by confirming what the patient has just said. Then, the patient confirms what the chaperone has said before the chaperone adds a further account. Hence, the analysis of the chaperone-patient alignment pattern has revealed five sequential actions performed by the participants, namely (1) *the doctor's medical question directed to the patient*, (2) *the patient's response*, (3) *the chaperone's expansion (or confirmation) on the patient's answer*, (4) *the patient's confirmation*, and (5) *the chaperone's further account*. Each action or pattern reveals different practices used by the chaperones and the patients to accomplish alignment and affiliation with each other. The alignment sequences during the history-taking and treatment phases were organised in line with the five elements noted above. It is important to note that although the five actions were not displayed in every extract, each extract has enough of the element to warrant the claim that there is a pattern. Below, I provide an example from an extract taken from the Chemotherapy Clinic which shows the sequential actions of chaperone-patient and patient-chaperone alignment. These actions are displayed in alphabetical order.

**Extract 6.7. H3 V 63 D 23 Da.7/1/2012 Cl. Chemo-th. (Pt: 50; her husband aged 60)**

- 36 Dr1: (A) → li hma<sup>↑</sup> li h ma a a<sup>↑</sup> ki s hina?  
 37 Pt: (B) → ° gas ara ma fi .°  
 38 M.CH: (C)→ a u hum- a uha kyas filmustashfa wa  
 39 jinahum wa ga lu ma fi a d khala at<sup>↑</sup>  
 40 Pt: (D) → khala at.  
 41 M.CH: (E) → ma a u na ki a s laha.

- 36 Dr1: (A) → Why didn't<sup>↑</sup> why didn't you have<sup>↑</sup> a bag here?  
 37 Pt: (B) → There was no ° catheterisation. °  
 38 M.CH: (C) → They gave them –they gave her bags in the hospital and we  
 39 went again and they said there were none left, they were finished<sup>↑</sup>  
 40 Pt: (D) → They were finished.  
 41 M.CH: (E) → They didn't give us any bags.

In chaperone-patient (and patient-chaperone) alignments, alignment emerges from three significant practices. These are: (1) confirmation (i.e. by using the minimal alignment token, ‘yeah’, and by repeating the prior turn), (2) expansion, and (3) turn-completion. These practices are investigated in CA literature in relation to the norms governed by talk-in-interaction, particularly, with knowledge norms, (i.e. how participants orient towards certain subjects which are known to one or both parties) (see Chapter 7). The practices that emerged from chaperone-patient (and patient-chaperone) alignment are discussed below with reference to some extracts from the data

#### 6.4.1.2.1. Confirmation through the alignment token ‘yeah’

In the data gathered during the course of this study, there were 85 occasions when the patient was invited to confirm some medical issues while the chaperone confirmed what was said by the patient in the prior turn. For example, Extract 6.8 below involves an interaction between a 50-year-old patient, her 25-year-old daughter, and a male doctor. In the history-taking phase, at line 102, the consultant addresses the patient regarding the quantity of the medicine she has been taking. In addressing the patient (rather than the chaperone) by using the second person pronoun, the doctor indexes the epistemic priority of the recipient by requesting her to confirm. The physician’s confirmation question is designed in line with what Labov and Fanshel (1977) called an “*a b-event statement*” (p. 100).

**Extract 6.8. H3 V61 D23 Da. 7/1/2012. Cl. Haem. (Pt: aged 50; her daughter: aged 25)**

- 97 Dr1: =ya ni ma bta khdhi sh ala u l il bta <sup>3</sup>ghuda?  
 98 Pt: la ma a khudh kul ala u l, habitli iltiha b.  
 99 Dr1: ma hwwa hwwa bta > <sup>3</sup>ghuda da ma bi milsh iltiha b wala,  
 100 a ga <ka n bta khdi minu haba t, =  
 101 Pt: = iggi r i h.  
 102 Dr1: → iggi r illi hi a ka n khamisa w ishri n micru gram illi bitakhadhiha?  
 103 Pt: → iwah.  
 104 F.CH: → iwah iwah.  
 105 Dr1: <khala khaliki mashya ala ↑ tala tah.>  
 106 <ayi b at-ta li l <sup>3</sup>hamdu ↑ l-lah kuwais bita ik.>
-

97 Dr1: =you don't constantly take the drug for your glands?  
98 Pt: No, I don't take it constantly as it causes a burning sensation.  
99 Dr1: The one which is is for >glands doesn't cause any burning,  
100 nothing <you used to take a tablet, =  
101 Pt: =a small one yes.  
102 Dr1: → Small—which was the twenty five milligram tablet?  
103 Pt: → Yeah.  
104 F.CH: → Yeah yeah.  
105 D1. Okay continue taking three tablets.  
106 D1. <Okay your tests thank God↑ are good.>

In response to the doctor's confirmation question (line 102), both the patient and her daughter respond with the same actions (i.e. confirmation) by using the same token (i.e. "yeah"; line 103 & 104). Their responsive actions display their understanding that the doctor's turn (line 102) performs a specific action, namely a simple request for confirmation. In terms of alignment, the patient's use of "yeah" aligns with the doctor's request in line 102, which indicates that she accepts her interactional role as a recipient and at the same time supports the progress of sequential interaction. In terms of affiliation, the chaperone repeats the same token twice, "yeah yeah," to indicate confirmation and to affiliate and support the patient's agenda. After the patient's confirmation, the doctor proceeds to the next action in line 105 (i.e. advice to continue taking the same quantity of medicine) and 106 (assessing the patient's blood test).

The minimal responses given by both the patient and her chaperone exhibit their understanding of the status of the questions and their preparedness to confirm that understanding (Stivers & Heritage, 2001). Such conforming responses, according to Heritage and Raymond (2012), exhibit three important features. First, they are indexically associated to the question. Second, they unconditionally acquiesce to the terms of the questions by exerting no effort in expanding and elaborating the answer, which explains the maxim that "little questions get little answers" (Heritage & Raymond, 2012, p. 8). Third, they increase the progressivity of the question-answer sequence, until sequence closure is reached.

Similarly, in Extract 6.9, at line 34, the physician implements the practice of selecting the patient to be the next speaker by addressing a question to the patient, using the pronoun "you" (Lerner, 2003). The physician seeks confirmation pertaining to whether or not the doctor who performed the ultrasound for the patient was a male.

**Extract 6.9. H1 V6 D3 Da. 06/12/2011. Cl. Chemo-th. (Pt: aged 36, her husband: aged 41)**

- 32 Dr1: <mi\_n sa wa lik<sup>3</sup> ashi a? >  
33 Pt: a ad-duktu r<sup>o</sup> ka n duktu r .<sup>o</sup> =  
34 Dr2: → huwa duktu r illi sa wa lik<sup>3</sup> ashi a?  
35 Pt: → i\_wah.  
36 M.CH:→ i\_wah.  
37 Dr1: tishtiki n min shai ?

- 32 Dr1: <Who did the ultrasound for you?  
33 Pt: Erm a male doctor<sup>o</sup> it was a male doctor.<sup>o</sup> =  
34 Dr2: → It was a male doctor who did the ultrasound?  
35 Pt: → Yeah.  
36 M.CH: → Yeah.  
37 Dr1: Do you have any complaints?

The patient confirms their response by using the alignment token “yeah” (line 35). Then, the chaperone supports the patient by responding with a straightforward confirmation using the minimal token ‘yeah’ line 36.

In summary, the format of the physician’s question is designed to obtain a short and unelaborated answer. The patient aligns with the physician’s confirmation question while the chaperone supports the patient by confirming through the alignment token ‘yeah’ what the patient has just said. Having done that, the chaperone treats the patient’s response as adequate and succinct, thus requiring no elaboration. The chaperone’s affiliation with the patient adds more credibility to the patient’s factual claim and at the same time reinforces its factuality (Sidnell, 2012). Therefore, the physician treats the collaborative responses of both patient and chaperone as complete and shifts focus to a different activity.

Confirmation by ‘yeah’ is not the only practice which forms chaperone-patient alignment, alignment through repetition is another type as shown below.

#### **6.4.1.2.1.1. Confirmation by repetition**

The use of repetition to confirm the patient’s own claim was identified in 94 consultations. In Extract 6.10 below, the patient presents her complaint regarding pain in her bones. The doctor, in the history-taking phase, addresses the patient by using

the personal pronoun “you” asking her to specify which nerve is tight when she is praying, “When you pray, where is the nerve that is tight?” (line 55).

**Extract 6.10. H3 V 89 D 31 Da. 25/01/2012 Cl. Chemo-th. (P: aged 62, her daughter aged: 23)**

55 Dr1: → a h lamma t ali inti <sup>3</sup> a ab fi n illi yitshadad ?  
56 Pt: → hina .  
57 F.CH: → hina .  
58 Dr1: → mumkin turu ri ala alsareer afhasik?  
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55 Dr1:→ When you pray, where is the nerve that is tight?  
56 Pt: → Here.  
57 F.CH → Here  
58 Dr1: Can you get onto the bed so I can examine you?

With regards to the patient’s response, she aligns with the doctor’s question by referring to the location of the nerve that is tight (“here”). The female chaperone positively supports the patient’s stance by confirming through repetition the patient’s lexical item “here”. The chaperone’s repetition indicates her support of the patient’s factual claim that she has epistemic entitlement and authority to show the doctor the location of the pain, as she is the primary and eligible speaker regarding her illness.

Similarly, in Extract 6.11 below, repetition is used to confirm the patient’s factual claim by partially repeating what she said. Here, there was a discussion in the prior turns regarding performing an x-ray, which is easy to do in the place where the patient lives. The doctor seeks confirmation from the patient using the pronoun “you,” indicating that she should be the next speaker. The doctor asks the patient whether or not she lives in Madina<sup>77</sup> (“do you come from Madina, or where?”) (line 140).

**Extract 6.11 (continued from extract 6.10 above) H3 V 89 D 31 Da.25/01/2012 Cl. Chemo-th. (P: aged 62, accompanied by 23-year-old daughter)**

137 Pt: <sup>3</sup> a la tigu l mustagira shwai a?  
138 Dr1: a ::h,  
139 Pt: [<sup>3</sup> amdu lila h.  
140 Dr1: → [ inti bti gi mnilmadi na walla mni n? =

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<sup>77</sup> Almadina is the second most important Islamic city after Makkah, which is located three hours’ drive from Jeddah.



141 Pt: → = i h, a ji manilmadi na.  
 142 F.CH: → manilmadi fffffa.  
 143 Pt: → ili indak<sup>3</sup> i n kam sa a ? heh heh  
 144 F.CH: → min<sup>3</sup>madi na.

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137 Pt: You said that the situation is a little bit stable?  
 138 Dr1: Ye::s ,  
 139 Pt: [Thanks Allah.  
 140 Dr1: → [Do you come from Madina or where? =  
 141 Pt: → =I come from WHERE? Yeah, I come from Madina.  
 142 F.CH: → from Madin(£££££)a.  
 143 Pt: → For how long have I been with you now for how many years? heh heh  
 144 F. CH: → From Madina.

In response, although the patient misaligns with the physician's question by redirecting a teasing question to the physician (especially as she laughs), (line 141) "I come from WHERE?", she then ends her turn by a minimal, positive alignment token "yeah" followed by a confirmation "I come from Madina". In terms of affiliation, the chaperone supports the patient's stance by repeating the patient's last constructional unit (line 142) (from Madin(£££££)a. ) in a smiley voice, (displayed by the use of a pound £ sign), which is effectively affiliated to the patient's previous response. The use of an uplifting voice in the chaperone's response aims to affiliate and mark a positive and ironic stance with the patient's prior turn (Auburn & Christianne, 2013; Haakana, 2010). Therefore, the chaperone's demeanour serves to maintain affiliation and develop the progressivity of the conversation. With respect to the patient-chaperone alignment, the patient aligns with the chaperone's smiley voice by designing an ironic turn (line 143) and using an interrogative question directed at the oncologist, "For how long have I been with you now— for how many years? heh heh" followed by laughter to indicate that there is something wrong, i.e. that the oncologist should know his/her long-term oncology patient. It is important to note here that the patient's laughter (line 143) is designed to occur after the smiley voice to manage the interactional trouble (Haakana, 2010). The chaperone in line 143 confirms that they come from Madina.

In short, repetition is used as a type of confirmation by affirming the correctness of the patient's epistemic right indicated in the previous turn. This type of confirmation asserts the patient's primary rights and authority regarding the claim she

made. However, sometimes the patient's confirmation by 'yeah' or repetition is insufficient and needs more clarification and expansion on the part of the chaperone, as seen in the following section.

#### 6.4.1.2.2. Alignment through expansion

The data analysis revealed that the chaperone's expanded responses occurred in 75 consultations. On examining two instances of chaperone expansion, the chaperone departs from the patient's minimal responses (i.e. "yeah") by expanding upon them to build or add to the comprehensive history-taking. In Extract 6.12 below, the patient has no knowledge of her real illness<sup>78</sup> (see Chapter 7). She was accompanied to this specific appointment by her son and daughter. By asking if there are any complaints, the physician seeks confirmation of a factual question explicitly directed at the patient using the second person pronoun "you". Thus, the patient responds to the physician's question regarding whether or not she has any complaints and if she would like to inform the physician of any issues (line 15).

**Extract 6.12. H3 V 13 D8 Da.18/12/2011. Cl.Chemo. (P: aged 70; chaperones: her son: aged 37, her daughter: aged 40**

15 Dr1: fi iyi aa a ma shakil? iyi aa shakwa ? ti abi tu uliha li ? =  
 16 Pt: =<sup>3</sup> amd lil-lah↓, ila indi :: ya ni khumu l ↑ madri huu min  
 17 <sup>3</sup>kima wi ? (.) ma a d gidrat agu m (.) madri wu min SHAI ?  
 18 Dr1:→ ya ni ma ti dari sh tu wimi min lam rukabik? wal-la  
 19 → ti dari sh tu wimi min i h?  
 20 Pt: → i wa  
 21 F.CH: → JISMAHA ↑ kullah↑ ta ba n=  
 22 Pt: → =jismi ↑ kullah↑ ta ba n.

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 15 Dr1: Are there any problems? Any complaints you would like to tell me about? =  
 16 Pt: =Thank God↓, I am:: lazy ↑ I don't know is it due to the  
 17 chemo?<sup>79</sup> (.) I couldn't stand (.) I don't know is it caused by SOMETHING?

<sup>78</sup> It is important to note here that this patient has no knowledge of the fact that she has had cancer for two years. Knowledge asymmetry is a topic of the next chapter (Chapter 7).

<sup>79</sup> Most of the patients who were observed were illiterate. They do not know what chemotherapy means or even what a tumour is. They were informed that chemotherapy is like an antibiotic or nutrition injection. During the data collection, I had the chance to enter the inpatient chemotherapy room with one of the patients to assist in filling in the questionnaire. On our way to the inpatient chemotherapy room, the female chaperone reassured her mother that everything would be okay while taking the nutrition injection and she would be with her as soon as I had finished filling in the questionnaire

- 18 Dr1: → You couldn't stand from the pain in your knees? Or  
 19 → you couldn't stand because of what?  
 20 Pt: → Yeah  
 21 F.CH: → HER BODY↑ as a whole ↑ is ill=  
 22 Pt: → =My body↑ as a whole↑ is ill.

In response to the doctor's information-seeking question, the patient expresses her vagueness regarding the laziness she had experienced, indicating that she is unsure whether this pain was due to the chemotherapy or from something else (line 16 & 17). In the problem solicitation phase, the doctor addresses the patient in order to seek confirmation by making suggestions with regards to possible responses, such as whether the patient couldn't stand because of the pain in her knees or something else "—"You couldn't stand from the pain in your knees? or you couldn't stand because of what?" (line 18 & 19). In response to the prompt, the patient aligns with the physician by responding with confirmation of the first option in the doctor's question "—"You couldn't stand from the pain in your knees?" (line 18) using the minimal alignment token "yeah" (line 20). Therefore, as the female chaperone considers her mother's response insufficient, she uses expansion to amend the patient's turn. The female chaperone expands on the patient's "yeah," which is not enough to explain the patient's complaint. She expands on the patient's previous turn, specifying through emphasis and describing with extreme case formulation (Pomerantz, 1986) to strongly legitimise or portray the patient's complaint, "HER BODY↑ as a whole ↑ is ill" (line 21). The chaperone's reference to "her body" indicates that the patient's body is, in fact, ill. In a latched voice, the patient affiliates with her daughter by repeating what the chaperone has just said, 'my body↑ as a whole↑ is ill' (line 22).

Similarly, in Extract 6.13, during the history-taking phase, as the patient presents her complaint as "diarrhoea", the doctor designs his question to request more information from the patient concerning the diarrhoea she has, "but if you have it↑ do you go to the bathroom two or three times a day?" (line 108). The use of "two or three

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with her mother. This shows that not only are the oncologists and chaperones aware of not explaining the meaning of chemotherapy, but also the nurses who are working in the inpatient chemotherapy department.

times a day” is designed here to indicate or assess whether or not the patient’s diarrhoea is severe, as she has a bowel motion “more than once”. The physician’s question not only prompts the patient to confirm but requires the patient to describe, from her experience, what constitutes her problem (Stivers & Heritage, 2001).

**Extract 6.13. H3 V45 D18 Da. 31/12/2011. Cl. Chemo-th. (Pt: aged 69, her daughter: aged 35)**

108 Dr1: → la kin law ga lik<sup>↑</sup> tru i mariti n talata  
 109 filyu m?  
 110 Pt: → i ::wa.  
 111 F.CH: → > a ian akthar. <  
 112 D1: mai a kha li ? walla  
 113 P: mai a.

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108 D1: → But if you have it<sup>↑</sup> do you go to the bathroom two or three times  
 109 a day?  
 110 P: → Ye:ah.  
 111 F.CH: → >Sometimes more. <  
 112 D1: Is it liquid ? Or  
 113 P: Liquid.

In response to this, the patient offers a minimal response by using the alignment token “yeah,” confirming that she goes to the bathroom two or three times a day. As a result, in a quick turn, the female chaperone treats her mother’s response as insufficient. Thus, she provides a supplemental statement “sometimes more” (line 111) to elaborate on and support the patient’s minimal response. While the chaperone’s expansion could be based on her objective and external judgement or observation, it is achieved in a way that is “congruent with fundamental history activity in play” (Stivers & Heritage, 2001, p. 160). Consequently, the doctor continues asking questions about the patient’s symptoms in the following turn (line 112).

In summary, it is shown that the chaperone’s expansion on the patient’s responses displays her orientation in collating relevant information (by giving symptom description) about the patient’s history-taking phase that helps the physician in the diagnostic stage. The chaperone uses expansion to amend the patient’s turn (Aronsson & Rindstedt, 2011; Stivers, 2001). In doing so, the chaperone positions

herself with the patient's stance, showing that the patient's minimal response is insufficient and it has to be expanded and clarified to the doctor.

Chaperone-patient alignment is not only restricted to expansion but also includes completing the patient's turn construction unit to maintain alignment in the on-going interaction, as seen in the following section.

#### 6.4.1.2.3. Alignment through turn completion

The chaperone's turn completion of the patient's prior turn occurred in 78 consultations. Such affiliating actions, according to Lerner (2004), are characterised by (1) maintaining alignment and progressivity of the ongoing turn by the placement of a pre-empting utterance; (2) bringing the turn-in-progress to its possible completion; and (3) requiring no special cohesive tying devices (e.g. and, so). In Extract 6.14, after the physician assesses the patient's tests as "good" (line 42), the patient presents her complaint (i.e. pain in her bones). The doctor seeks further specific information regarding the patient's pain in her bones without directing this question to a specific speaker "joints or in feet as well ?="

**Extract 6.14. H3 V 90 D 31 Da.25/01/2012 Cl.Haema-th. (Pt: 62, her daughter: aged 35 )**

42 Dr1: = at at-ta ali l ai ba<sup>3</sup> amdu lila h ↓ kwai (hhh)sa. =  
 43 Pt: <sup>3</sup> amdu lila h ↓ bas ↑ ana ma a i ala m fi ah - fi a mi ,  
 44 D1: → filmafa il walla filrigl ka man? =  
 45 Pt: → kulaha :: ha dhi <sup>3</sup>mafa il min ind taba an ar-rukba ha dhi ↑ =  
 46 → > matthlan la ma aba ana kida a ali ,<=  
 47 F.CH: → =ma tigdar tirka =  
 48 Pt: → = ma agdar arka , a is <sup>3</sup> a ab ma i mitshadid (hhh).

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 42 Dr1: =The tests are good, thanks Allah ↓ goo(hhh)d. =  
 43 Pt: Thanks Allah ↓ but ↑ I have pains in my back- in my bones,  
 44 Dr1: → In joints or in feet as well?=  
 45 Pt: → = in a::ll of the joints from of course this knee ↑ =  
 46 Pt: >For example, if I want to pray,<=  
 47 F.CH: → =She cannot kneel.=  
 48 Pt: → =I cannot kneel, I feel that the nerve is tense (hhh).

In response to this, the patient elaborates that the pain in her joints is coming from the knee. She uses a confirmation marker "of course" (Stivers, 2011) before

referring to the pain in her “knee”; “in all of these joints from of course this knee” (line 45). When the patient gives an example of her illness symptoms, in a latched and quick turn without any gaps or pauses, (line 46), her female chaperone supports her mother’s stance by completing the patient’s turn confirming her mother’s inability to kneel when she prays, “=she cannot kneel.=” (line 47). Here, the placement of the affiliating utterance “=she cannot kneel.=” is central in announcing a symptomatic problem. The patient—who has the primary authority to either confirm or reject the chaperone’s TCU completion—examined the chaperone’s utterance and accepted it by confirming the first turn and by expanding on it, “I cannot kneel, I feel that the nerve is tense” (line 48). Thus, the patient has taken the chaperone’s claim as an actual symptomatic problem.

Furthermore, in Extract 6.15, the patient presents her complaint as having “constipation” line 65. The doctor designs a turn specifically and explicitly directed at the patient, using the second person pronoun “you,” to seek confirmation with regard to the patient taking medicine for constipation, “Do you take medicine for the constipation?” (line 66). In response, the patient confirms that she takes medicine, “I take medicine” (line 67).

**Extract 6.15. H3 V 14 D 9 Da.19/12/2011 Cl. Chemo-th. (Pt: aged 70; her son, aged 38)**

64 Dr1:        tishtiki n min shai ?  
 65 Pt.        iwah iimsa k  
 66 Dr1:    → bitakhadi ilag lliimsa k?  
 67 Pt.        → khud ilag =  
 72 M.CH. → =bidu n i faiydah↓=  
 73 Pt.        = ilag bidu n i faiydah =  
 74 M.CH.    =bass yawm sau lana (.) aaa<sup>3</sup> shi ah<sup>3</sup>maq a i ah,↓  
 75            (0.1) ma sha al-la h ta asanat ya ani  
 76 Dr1.        IWAH,

-----  
 64 Dr.1.        Do you have any complaints?  
 65 Pt.        Yeah I have constipation  
 66 Dr1:    → Do you take medicine for the constipation?  
 67 Pt.        → I take medicine=  
 72 M.CH. → =>it’s no use<.=  
 73 Pt.        → =I take medicine but it’s of no use.=  
 74 M. CH.    =But the day they did (.) aaa the CT scan,↓

75 (0.1) thank God she is getting a little bit better.  
76 Dr1. OKAY,

In terms of the chaperone's affiliating and supporting response, the male chaperone in the example above supports the patient's stance by completing the patient's turn—without any gaps and pauses and by using a quick turn—negating any usefulness of the medicine (line 72). In a latched voice, the patient, who has the primary authority to validate the chaperone's proposed knowledge, confirms the chaperone's prior turn by repeating what her son has just said (line 73).

To sum up, in the above extracts, the chaperone displays support and endorsement for the patient's stance or affiliation by completing the patient's turn. The patient, as the legitimate person with the knowledge, has the right to accept the chaperone's proposed claim or to expand, as seen in Extracts 6.14 and 6.15.

Therefore, the analysis of the extracts from the history-taking stage, shown above, has revealed an emergent theme pertaining to chaperone-patient and patient-chaperone alignment and affiliation. In addition, chaperones and patients achieve alignment and affiliation during medical interaction through various practices, including confirmation (by alignment token, 'yeah' and by repetition), expansion, and turn completion. All these actions indicate that both participants are collaboratively involved in the interaction. Finally, it is important to note that chaperone-patient and patient-chaperone alignment and affiliation share something in common, as both maintain the progressivity of the on-going conversation.

Chaperone-patient and patient-chaperone alignment are not the only type of alignment observed in three-party medical consultations, but chaperone-doctor (and chaperone-patient) is the third type as well. This type of alignment is discussed below.

#### **6.4.1.3. Chaperone-doctor and chaperone-patient alignment**

In chaperone-doctor and chaperone-patient alignment, the chaperone forms an alliance with the doctor acting as a supporting chaperone, especially in negotiating the treatment plan. The physician discusses the treatment plan and treatment recommendations with the patient and explains what the patient is required to do. Chaperone-doctor alignment occurred in 56 consultations. The sequential actions that have emerged from chaperone-doctor and chaperone-patient alignment pattern are (1)

*the doctor's medical questions directed at the patient, (2) the patient's response, (3) the doctor's recommendations, (4) the chaperone's repetition of what the doctor has just said, and (5) the patient's confirmation.* These sequential actions are clearly shown in the following extract taken from the Chemotherapy Clinic. The sequential actions are organised in alphabetical order.

**Extract 6.16. H3 V 85 D 29 Da.18/1/2012 Cl. Chemo-th. (Pt: 43; her sister: aged 35)**

319 Dr1.            ila g ki ma wi ba wlik wighit nazari ana  
 320                    ISH-SHAKHi ah innu a - ib <sup>3</sup>badi l, da ↑ nilga li ba d (0.1)  
 321                    ma tafshal kulila illa wasa il ila <sup>3</sup>ilmi a <sup>3</sup>ma ru fa ya ni .  
 322                    hhh (0.1) ana afa al kida ya ni ma fa alshi ininti  
 323                    tilga i li - ib <sup>3</sup>badi l <sup>3</sup>AWI(h)L (.) wa ba di n lamma  
 324                    yifshal nilga lil lilki ma wi tuku n l <sup>3</sup> a la it akharit  
 325            (A)→ fahmani?  
 326 Pt.    (B)→ i wah.  
 327 Dr1. (C)→ wighit nazari ana ink la tibda i ila g ki ma wi  
 328                    min <sup>3</sup>yaum  
 329 F.CH. (D)→ la zim tibda i ila g ki ma wi  
 330 Pt.    (E) → tai b.

-----  
 319 Dr.1            in my PERSONAL opinion chemotherapy is better↑  
 320                    than this alternative medicine, we sometimes resort to after  
 321                    (0.1) the failure of all the known scientist methods.  
 322                    hhh (0.1) I don't wish you to resort to  
 323                    alternative medicine FIRST (.) and then when it fails  
 324                    we resort to chemo as in this case it is too late  
 325            (A) → Do you understand me?  
 326 Pt.    (B) → Yeah.  
 327 Dr1. (C) → From my personal point of view you have to start  
 328                    chemotherapy from today  
 329 F.CH. (D)→ You have to start chemotherapy  
 330 Pt.    (E)→ Okay.

Chaperone-doctor and chaperone-patient alignment tends to be repeated in its sequential actions in chemotherapy clinics, and I will analyse one extract of this type. In Extract 6.17 below, the patient had cervical cancer in the past and the tumour was removed. Now, the tumour has spread to the liver and the spleen and is thus classified as fourth stage cancer. The patient does not know this, as ONLY her husband has been informed of the severity of the disease (see Chapter 7 regarding epistemic asymmetry). In discussing the treatment plan for the patient's medical condition, the oncologist



negotiates chemotherapy treatment and treatment recommendations with the patient and advises her of what she has to do. After the patient is examined by the resident doctor, the consultant and the resident discuss the patient's x-ray (data not shown), after which the consultant explains to the patient that she is going to take a drug (line 87-88) with the emphasis on the word "drug." Next, the doctor seeks confirmation from the patient as to whether or not she understands, "Look, madam, now, the medication that you're going to take is A DRUG (.) okay?"

**Extract 6.17. H3 V 63 D 23 Da.7/1/2012 Cl. Chemo-th. (P: 50 year old patient accompanied by 60 year old husband)**

87 Dr1: bu i ya sitti dilwa ti <sup>3</sup> ila g illi a ritik atakhdi dawa t  
 88 MALU L (.) ha h ? =  
 89 Pt. = i wa.  
 90 Dr1: → biyita khid marra kuli talat asabi ,=  
 91 M. CH. → =takh i marra .  
 92 Pt. → i wa.  
 93 Dr1. wa da wa da yata allab<sup>↑</sup> ba ila ila i tya a t<sup>↓</sup> ha ?=  
 94 Dr1. <sup>3</sup> i tya a t di <sup>↑</sup> ini inti lazim tishrabi  
 95 → mayya, wa sawa i l KITI R.  
 96 M. CH: → inti lazim tishrabi mayya, wa sawa i l KITI R=  
 97 Pt: → = ai wa.  
 98 Dr1: MAYYA (.) WA SAWA (.) I l KITI R. ha h?  
 98 Pt: ai wa.

-----  
 87 Dr1: Look madam, now, the medication that you're going to take  
 88 is A DRUG (.) huh? =  
 89 Pt: =yeah.  
 90 Dr1: → It is to be taken once every three weeks,=  
 91 M.CH: → =you must take it once.  
 92 Pt: → Yeah.  
 93 Dr1: And this requires <sup>↑</sup> some pre pre prerequisites <sup>↓</sup> okay? =  
 94 Dr1: These<sup>↑</sup> prerequisites are that you must drink  
 95 → Plenty of <sup>↓</sup> water and liquids  
 96 M.CH: → You have to drink PLENTY of water and liquids=  
 97 Pt: → =yeah.  
 98 Dr1: PLENTY<sup>↓</sup> WATER (.) AND LIQUIDS. huh?  
 99 Pt: =yeah.

The patient confirms in a latched voice using the alignment token "yeah" (line 89). The doctor continues explaining that this drug is taken once every three weeks

(line 90). In terms of chaperone-doctor alignment, the chaperone aligns with what the doctor has just said by reformulating the doctor's utterance and directing it at the patient by using the personal pronoun "you" (line 91), "=you must take it once." in a latched voice. In terms of patient-chaperone alignment, the patient aligns with the chaperone by accepting the treatment plan using the alignment token "yeah" (line 92).

Similarly, as the treatment plan needs a treatment recommendation, the doctor warns and advises the patient to drink plenty of water, with empathic intonation on "PLENTY" in line 94-95 "these<sup>↑</sup>prerequisites are that you must drink plenty<sup>↓</sup> water and liquids." Demonstrating chaperone-doctor alignment, the chaperone uses repetition, reiterating what the doctor has just said, but directing his utterance to the patient by using the pronoun "you" (line 96) "you have to drink PLENTY of water and liquid." When responding, the patient aligns with the chaperone by using the alignment token, "yeah" (line 97) and accepting the treatment plan.

To sum up, in chaperone-doctor alignment, the chaperone aligns with the consultant line-by-line by shifting alignment to the patient to solicit confirmation from the patient regarding what she is required to do during the chemotherapy treatment. As shown above, the chaperone exerts efforts to involve the patient in the interaction concerning the treatment part of the consultation. Therefore, the chaperone is perceived as showing a caring<sup>80</sup> attitude and responsibility regarding the patient's decision-making with respect to the treatment plan.

Having discussed the three types of alignment, (i.e. doctor-patient; chaperone-patient; and chaperone-doctor) that emerged from the audio-recorded data, the next step is to investigate whether the pattern of alignments are specifically gendered. As investigated in Chapters 4 and 5, some variables (i.e. patients' education, age, and the chaperone's gender) have a significant effect on patient satisfaction with chaperone involvement in medical consultations; the social identity of the interlocutor according to CA methodology is only relevant in the conversation. Looking at the participant's gender is against CA assumption. The aim of investigating gender here, although it is

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<sup>80</sup> Previous Conversation analysis and Discourse analysis studies (Aronsson, 1991; Aronsson and Rundström, 1988; Lee and Kim, 2015; Stivers, 2002) perceived the chaperone as a caring family member during triadic medical interaction.

beyond the CA methodology, is to give a complete picture about what variable matters more in chaperone involvement in medical consultations.

Therefore, the next section discusses the second part of the third research question in this thesis, (i.e. do chaperones' alignments vary according to chaperone gender?)

#### **6.4.2. Gender variation in alignment**

In this section, I will discuss the findings of the second part of the third research question of this thesis. The research question is:

##### **Do chaperones' alignments vary according to chaperone gender?**

In analysing the audio-recorded data, it has been observed that there is no reference to gender in patients' utterances during three-party interactions. Gender seems not to be relevant to the patient, i.e. there is no explicit use of a gendered term (e.g. he, my son, my daughter) in patients' turns as shown in Chapter 5. Therefore, gender goes unnoticed. However, the patterns of alignments discussed above seem to be specifically gendered, therefore, two procedures were followed to check if gender plays a role or makes a difference. The frequency between chaperone-patient and chaperone-doctor alignments was examined by (1) consultation and (2) by the number of instances across the data between male and female chaperones without looking at opportunities or possibilities for alignment between the three parties in the medical consultation.

To investigate differences in alignment patterns, each consultation was examined separately. That is to say, I counted types (1) (i.e. doctor-patient) and (2) (chaperone-patient) of alignment as a coherent set in one consultation. I carried out the same procedure for the third type of alignment (i.e. doctor-patient, chaperone-doctor alignment). Any repetition of this set is not counted. However, when examining the second and the third types of alignment, (e.g. chaperone-patient or

chaperone-doctor alignment) by counting the instances across the data, there seems to be a gender difference. The findings are discussed below.

#### 6.4.2.1. Chaperone-patient alignment

Table 12 below shows the proportions of male and female chaperones within each practice of alignment by consultation (i.e. *confirming by 'yeah'*, *confirming by repetition*, *expansion*, and *turn completion*). It is observed that both genders are aligning with the patient. For example, in *confirmation by repetition*, the corresponding percentages are 49 (52%) for male and 45 (47%) for female chaperones. For *confirmation with 'yeah'*, the corresponding percentages are 47 (55%) for male and 38 (44%) for female. The percentages of the remaining two alignments are shown in Table 12.

**Table 12:** Frequency of chaperone-patient alignment by consultation

Practices of alignment	Turn 1	Turn 2	
	Doctor-patient alignment	Chaperone-patient alignment	
		Male N (%)	Female N (%)
Confirmation with 'yeah'	85	47 (55%)	38 (44%)
Confirmation by repetition	94	49 (52%)	45 (47%)
Alignment through expansion	75	44 (59%)	31 (41%)
Alignment through turn completion	78	43 (55%)	35 (45%)
<b>Total</b>	<b>332</b>	<b>183</b>	<b>149</b>

This table indicates that overall male chaperones align more with the patients than female chaperones as the proportion of males is consistently higher than that of female chaperones.

However, when examining chaperone-patient alignment by instances across the data, gender differences do stand out as shown in Table 13 below.

**Table 13:** Chaperone-patient alignment by instances

Practices of alignment	Turn 1	Turn 2	
	Doctor-patient Alignment	Chaperone-patient alignment	
		Male N (%)	Female N (%)
Confirmation with ‘yeah’	277	213 (77% )	64 (23%)
Confirmation by repetition	283	208 (73%)	75 (26%)
Alignment through expansion	141	103 (73%)	38 (27%)
Alignment through turn completion	126	83 (74%)	43 (38%)
<b>Total</b>	<b>827</b>	<b>607 (75%)</b>	<b>220 (27%)</b>

Table 13 shows the proportions of males and females within each practice of alignment. For example, alignment by *repetition* is used more frequently by male chaperones 208 (73%) than their female counterparts 75 (26%). Similarly, *confirmation with ‘yeah’* is used by male chaperones 213 (77%) in confirming female patient’s prior utterances more than their female counterparts 64 (23%). The percentages of the remaining two alignments are shown in Table 13. The gender alignments shown in Table 13 above indicate that a higher proportion of male chaperones was present in each practice of alignment compared to their female counterparts. The fact that this proportion is greater in males than females might be due to male chaperones in my data being higher in number (58) than female chaperones (47).

#### 6.4.2.2. Chaperone-doctor alignment

On investigating gender variation in chaperone-doctor alignment by consultation, a higher proportion of male chaperones—33 (59%)—tended to repeat the doctor’s prior turn concerning the patient’s treatment plan compared to females—23 (41%). Similarly, for the frequency of chaperone-doctor alignment by instances, a higher proportion of male chaperones—44 (61%)—used repetition compared to females—27 (38%).

To summarise, findings concerning gender variation have shown that male chaperones are more active in aligning with the patients than their female counterparts by confirming patients’ prior turn using repetition and the alignment token ‘yeah’.

Similarly, in chaperone-doctor alignment findings have shown a higher proportion of male chaperones compared to their female counterparts tended to repeat the doctor's recommendations to seek the patient's understanding about the treatment plan. The higher proportion of male chaperones to align with either patients or with doctors might be related to the fact that male chaperones in my data are higher in number (58) than their female counterparts (47). It may be that male chaperones behave differently with male doctors. It is possible that male chaperones had more positive and informative experiences aligning with male physicians than with females.

## **6.5. Summary**

In this chapter, I have introduced the concepts of alignment and affiliation in CA studies. I have also presented CA studies on alignment in three-party medical interactions. In the methodology of data analysis, I have displayed the main assumptions of CA as well as the steps to analyse the medical data. In addition, I have explored in this chapter three main types of alignment that took place in three-party medical consultations, namely, (1) doctor-patient alignment, (2) chaperone-patient alignment and (3) chaperone-doctor alignment. The findings reported here indicate that in the first type (i.e. doctor-patient) the patient aligns with the doctor when the doctor seeks confirmation or information from the patient during the history-taking and treatment phases. In chaperone-patient alignment, three important practices emerged during the history-taking phase: confirmation, expansion, and turn completion. In chaperone-doctor alignment, I have shown that in the treatment phase the chaperone aligns with the doctor line-by-line by involving the patient in medical interaction regarding her treatment plan.

My findings have also reported that the chaperone aligns either with the patient or the physician during medical interaction for various purposes: (1) to support and report factual information, (2) to maintain progressivity of the on-going interaction, (3) to reinforce the objective validity of the claims made by the patient, and (4) to remain an active, supportive and caring chaperone. Chaperones in this chapter are perceived as caring and responsible caregivers who are interested in patients' health.

In addition, both the physician and the chaperone treat the patient as the primary individual who has a primary right to respond when she is selected to be the

next speaker to discuss her illness and her body. It is important to note that identifying the three forms of alignment helped to answer the second part of the third research question of this thesis concerning gender variation.

The gender variation findings have shown that male chaperones tend to align with the patient and the doctor more than their female counterparts. The most recurrent practice of alignment used by male chaperones was confirming by repetition, (i.e. repeating either the patient's prior turn or the doctor's recommendations regarding a treatment plan). It could be that male chaperones had more informative experience dealing with male physicians than their female counterparts. It could also be that male chaperones in my data are higher in number (58) than that of their female counterparts (47).

In comparing the CA results of audio-recorded data in this chapter to the statistical analysis of quantitative data (see Chapter 4) as well as to thematic analysis of open-ended questions (see Chapter 5), it was observed that first, findings yielded by the CA showed no indication to patients' ages and education in their utterances. This suggests that investigating age and education in medical interaction is beyond the limits of CA. Second, there has been a discrepancy between what patients reported about their chaperones in Chapter 5 (i.e. speaking on their behalf) and the actual observation of three-party medical interactions in this chapter (see Chapter 8 for detailed information about integration of mixed method results). Chaperones orient to patients as the actual owners of their bodies and illnesses, and the aligning and affiliating responses either between chaperone-patient or chaperone-doctor co-operate with one another by facilitating the ongoing activity or sequence. Therefore, patients were given the chance to present their problems and report their history-taking to their physicians. Chaperones, in working collaboratively with patients and doctors, provide insights into their facilitative behaviour towards both the doctor and the patient.

In comparison with the chaperones' positive and facilitative attitudes presented in this chapter along with the previous chapters (4 and 5), Chapter 7 highlights a negative picture of their domineering behaviour in third-party medical consultations. The presence of a chaperone may dominate as well as complicate doctor-patient interaction and thus significantly override the patient's role. Therefore, Chapter 7 presents a case study of two exceptional situations where the patients either do not

know anything about their illness or at least do not know which stage of cancer they have reached. These case studies are two of just 17 cases, which is not rare. They are extremely important as they embody a real-life problem of knowledge asymmetry from third-party medical consultations which calls for policy intervention. In the exceptional cases investigated in the following chapter, patients are “behind-the-scenes” (Speice et al., 2000, p. 108) owing to knowledge asymmetry which leads to equivocation in three-party medical interaction. Therefore, misalignment and disaffiliation develop, the patient’s epistemic entitlement is breached, patient participation is impeded, and more importantly, doctor-patient trust is lost.



## CHAPTER 7

### Epistemic Asymmetry in Chemotherapy and Haematology Clinics: A Case Study

#### 7.1. Introduction

In Chapter 6, Conversation Analysis of audio-recorded data showed three forms of alignment (i.e. doctor-patient, chaperone-patient, and chaperone-doctor) which emerged during three-party interactions. These forms of alignment are achieved sequentially through organised actions that are logically ordered with the previous actions. Such structurally organised actions represent a set of norms which are strongly associated with participants' understanding of these norms, particularly epistemic norms regarding patient's epistemic primacy and access. The patient was treated as the primary person—when selected to be the next speaker—to speak about her body. The patient responded to the physician's question since she had full knowledge of her illness. Her chaperone acted as a support as well as a caring family member facilitating the patient, and also aided the physician's understanding when negotiating the patient's complaints or taking the history of patient's illness.

The act of questioning regarding the patient's complaints and history taking requires the patient's epistemic access, elicited access, and qualifying claim of access (Beach & Metzger, 1997; Stivers & Robinson, 2006). For example, as mentioned in Chapter 6, the epistemic norm is when the physician asks the patient a question (e.g. requesting confirmation or further information), he presupposes that the patient is the owner of her illness and thus has sufficient knowledge to answer the diagnostic questions (Sacks, 1984a; Stivers, 2001). Each question asked by the physician carries an important issue about the patient's epistemic primacy and epistemic status (Heritage, 2013). Thus, the physician expects the patient's willingness to answer as well as to have epistemic access about her illness more than her chaperone. The patient's response means aligning with a presupposition of epistemic access, otherwise, the inability to answer misaligns with the access and violates the norms of alignment and epistemic rights.

The norms of epistemic rights and status which are essential in a question-answer sequence can be problematic (see Chapter 2) for the patients (Lee, 2013), whose epistemic primacy and access are controlled under certain conditions (i.e. the chaperone's dominating attitude), particularly in medical interactions by the presence of a third-party and by socio-cultural norms (i.e. illness non-disclosure). Therefore, conversation analysis framework is used to identify a variety of ways in which epistemic or knowledge-norms are violated in three-party interactions.

Conversation analysis not only studies the organisation of alignment and epistemic norms (see Chapter 6), but also addresses when these norms are violated according to the socio-cultural norms regarding the disclosure of terminal illness, such as in cancer diagnosis of the Saudi female patients. As mentioned in Chapter 2, the Saudi society is based on strong family ties rather than patient autonomy (Aljubran, 2010). Therefore, the disclosure of cancer diagnosis is still related to the misconception of incurability (Khalil, 2013). To facilitate the misconception of cancer as a life-threatening illness, physicians tend to disclose cancer diagnosis to chaperones and conceal from, or even modify the unfavourable information given to the patients. Consequently, legislation concerning patient autonomy and truth disclosure have not yet changed in Saudi Arabia. Patients have no right to know the reality of their illness nor to report on their illness.

Therefore, the current chapter is a case study investigation of the epistemic asymmetry in three-party interactions with reference to two single and exceptional cases from chemotherapy and haematology clinics, where the patients do not know the extent of their illness. The reason for choosing two case studies is that they represent deviant cases from the rest of the data by manifesting the oncologist's and the chaperone's exceptional attitudes in breaching the patient's primacy (e.g. disease non-disclosure, and turn design). Thus, epistemic circumstances are in conflict and the epistemic resources among participants are incommensurate. Therefore, the aim of this chapter is to describe how epistemic asymmetry is managed and constructed in three-party interactions and what epistemic resources are used by the oncologist and chaperone to control the patient's participation and the amount of information given. The Conversation Analysis approach is used to uncover the various epistemic resources used by interlocutors to manage the dimensions of epistemic asymmetry

with reference to these resources for improving the quality of care. It is hoped that the findings of this chapter will contribute to developing a code regarding patient autonomy in Saudi Arabia.

For the construction of this chapter, it is useful, first, to review relevant research on epistemic/knowledge asymmetry from prior studies of Conversation Analysis (section 7.2). In section 7.3, I discuss a case study approach in investigating epistemic asymmetry with reference to the two single cases taken from oncology clinics. In addition, I describe the analytical procedures conducted in analysing the data, and present the two extracts from the data with a background summary on each case. In section (7.4), I discuss the Conversation Analysis results regarding how epistemic asymmetry is managed in three-party interactions and what are the epistemic resources used to control patients' primacy and access. The chapter ends by summarising the main findings of epistemic asymmetry in relation to the two case studies.

## **7.2. Knowledge in Conversation Analysis Research**

### **7.2.1. Knowledge as a norm-governed domain in Conversation**

#### **Analysis research**

Previous Conversation Analysis (CA) research on knowledge in social interaction has focused on knowledge as a norm-governed domain and the ways in which it is managed in interaction which potentially contributes to the overall organisation of the interaction (Sidnell, 2012; Stivers, et al, 2011). According to Stivers, Mondada & Steensig, (2011), knowledge in social interaction is regarded as a "moral domain" (p. 7) for managing social relationships. Conversation analysts (Heritage & Raymond, 2005; Heritage, 2010, 2011, 2012a, 2012b, 2013) have investigated the role of knowledge in organising social interaction and how speakers orient to certain subjects which are known to one or the other party.

Previous CA (Heritage, 1984a; 1984b) and pragmatics (Grice, 1975; Levinson, 2006) research has indicated that speakers' epistemic access, primacy (i.e. rights) and responsibility are governed by social norms which are influenced by alignment and affiliation (see Chapter 6) (Stivers, et., al., 2012). These norms are examined and synthesised by Stivers, et al., (2011: 9-13). Regarding epistemic access, there are two

important social norms: (1) speakers should not inform the recipient about what they already know regarding some subjects; and (2) speakers should not make claims about some subjects without having an adequate degree of access. This claim is similar to Grice's sub-maxim of quality which maintains "Do not say that for which you lack adequate evidence" (Grice, 1975, p. 41). Building on these maxims, Stivers, et al., (2011) suggest that the interactants control their interlocutors' epistemic access by devising their turns in terms of presupposed access. In addition, there are a variety of interactional practices to determine who has prior access to certain subjects, such as pre-announcement (and story preface, e.g. "Did I mention to you that I got yelled at by one of our neighbours today?") (Stivers, et al., 2011, p. 11), different forms of interrogative syntax (e.g. "Your line's been busy" (Stivers, et al., p. 11), morphology and prosody, and downgrading the degree of access, (e.g., I think, maybe, probably).

With regards to the social norms of epistemic primacy that interactants rely on to make claims or resist a claim, Stivers, et al., (2011) argue that speakers often not only orient towards asymmetries of their right to have access or to tell something but also to asymmetries in the degree (i.e. deep, specific, or complete) of their knowledge. The norm of speaker's rights to have access is derived from Sacks's (1992) legitimate speaker of information which suggests that new knowledge, particularly, "big news" (561) should be announced in order of relational closeness to the interlocutor who is concerned, giving a sense of who has a superior right to know. Breaching this norm of ordering can lead to disruption in the relational interaction. The second norm of epistemic primacy is concerned with the degree of knowledge. That is to say, the speakers with more authority and in-depth knowledge have primary rights to make assertions and assessments in this field (Heritage & Raymond 2005; Stivers, et al., 2011). Take, for instance, two different kinds of knowledge: a patient who has suffered from a chronic illness for years, and her chaperone who lives and observes the patient's experience of the illness. Although the patient's chaperone has a little epistemic access to the patient's illness, there is a clear difference with regards to who has in-depth knowledge and who has less epistemic access. Stivers, et al., (2011) explain the occurrence of each norm in the social interaction: the first resource takes place in sequential position. The second resource which is making assertions or an assessment in the first position gives a sense that the speaker has epistemic primacy

over the claim (Heritage, 2002). Consider the following example from my data: the oncologist seeks confirmation from the patient as to whether she has a complaint, (line 14). The patient aligns with the prior turn by confirming (using the alignment token, ‘yeah’) that she is in pain, line 15.

**Extract 7.1. H3 V27 D12 Da. 24/12/2011. Cl. Chemo-th. (Pt: aged 39; her husband: aged 46)**

14 Dr1 → tishtiki n min shai ?  
 15 Pt: → i wa fi(hhh) aLAM=  
 16 M. Ch: → = i wa fi alam  
 -----  
 14 Dr1: → Do you have any complaints?  
 15 P: → Yeah ther (hhh) e is pAIN=  
 16 M.CH: → =yeah there is pain

The chaperone immediately aligns and affiliates with the patient’s prior turn by confirming through full repetition that there is pain, line 16. By confirming through full repetition of the patient’s prior utterance, the chaperone confirms that the patient has stronger and primary rights to make the claim that she has pain. In doing so, the epistemic congruence is established for the chaperone to assert not only patient access but primacy as well.

Concerning the third norm, i.e. epistemic responsibility, speakers also have a responsibility with respect to what they know (i.e. first-hand experience) and what they do not know (Pomerantz, 1980; Stivers, et al., 2011). Thus, the interlocutor has the responsibility to design their turn (e.g. requesting information) from the next available recipient if he/she does not know the answer. In this case, the recipient has the responsibility either to claim epistemic access or to display a lack of epistemic access through managing epistemic status and stance in social interaction.

Recent CA research in epistemics has investigated the need to distinguish between ‘epistemic status’ and ‘epistemic stance’. An interactant’s epistemic right to access a targeted element of knowledge or information within a certain domain can be described as ‘*epistemic status*’ (Heritage 2012a). Epistemic status, according to Heritage, (2012a, p.4), is the:

Relative epistemic access to a domain or territory of information as stratified between interactants such that they occupy different positions on an epistemic gradient (more knowledgeable [K+] or less knowledgeable [K-]), which itself may vary in slope from shallow to deep.

The above quote shows that epistemic status is both relative and relational. The former means that at some point in time the interactants position themselves relative to what others know towards a given epistemic domain, whereas the latter (i.e. epistemic status is relational) inherently manifests itself <sup>81</sup> in an interaction between two or more interlocutors. Therefore, epistemic status is a real and enduring characteristic of social relationships that relates to participants' distribution of knowledge as well as to knowledge access towards a given epistemic domain (Heritage, 2012a, 2012b).

In contrast, epistemic stance describes how interactants construct and manage epistemic status through designing turns to speak. Epistemic stance—provided by interactants regarding a domain of knowledge—involves degrees of certainty of knowledge as well as commitments to the truth of propositions (Ochs, 1996). Therefore, certain linguistic, grammatical, and prosodic features of a turn can be used to make a distinction of epistemic stance on the axis of 'knowing' (K+) and 'unknowing' (K-) positions regarding a domain of knowledge. For example, an unknowing stance can be expressed by epistemic markers as 'I don't know' or 'I think' which locally downgrade the interactants' epistemic status (Heritage, 2012a; 2012b). Stivers, et. al., (2011) argue that the speakers can mitigate against the claim by downgrading the assertion by using either epistemic mitigation such as "I think" or "maybe" (Stivers, 2005) or by using a tag question (Heritage & Raymond, 2005). Therefore, the interactant's epistemic status and epistemic stance of knowing and unknowing positions have an impact on epistemic congruence in interaction.

The principle of epistemic congruence, according to Heritage, (2012a), occurs when unknowing speakers ask questions, and knowing recipients make assertions. Thus, epistemic congruence refers to the interactants' mutual understanding of their epistemic status (rights to know) and their epistemic stance (linguistic resources) encoded in a turn at speaking. Stivers, et al. (2011) further claim that epistemic

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<sup>81</sup> Itself here refers to the epistemic status regarding epistemic access of a certain state of affairs.

congruence does not only require agreement on who has primary access to a certain domain of knowledge but also agreement on who has relative epistemic primacy.

In medical consultations, the patient's epistemic primacy involves her responsibility to report her personal illness and describing her physical conditions that need urgent care. The patient's first-hand experience is considered more authoritative than the chaperone's limited access to what they have heard, seen or have even been told. The norms of reporting self-experience and describing what has been observed regarding a state of affairs are discussed in the following section within the frame of knowledge in CA research.

### **7.2.2. Self-experience and observation in Conversation Analysis research**

The epistemic domain involves an interlocutor's controlling access regarding his/her personal experience (Heritage, 2011; 2012a). Schütz (1962) argued that knowledge is socially constructed which is based on participants' daily life experiences that must be narrated to reveal the reality. For example, in a medical consultation, the social norm is that in presenting a complaint, the patient is considered as the autonomous individual who has the right as well as the authoritative source of knowledge to report her illness (Drew, 1991; Stivers, 2001). In reporting her own illness the patient tends to describe her body and the physical condition she feels as evidence of an illness that requires immediate care as seen in previous CA research (Lee & Kim 2015).

Previous CA studies have focused on patterns of knowledge asymmetries (that exist with regard to a person's rights to know) and types of knowledge which are 'experienced' versus 'observed' by people. In his article, "On doing being ordinary", Sacks, (1984a) focused on the notion of "entitlement to have experiences" (p. 424) when discussing the practices of storytelling. Sacks claims that having witnessed something, having seen and felt it, having suffered and lived an event is the entitlement to have an original as well as a personal experience, which is quite different from those recipients who might only observe that event. Therefore, the teller is entitled and has the right to report his/her personal experience which he/she encountered. On the contrary, the story recipient has no right to own or feel the teller's experience. Rather,

the story recipient is only entitled to have access to an event when hearing the story or reporting it to another party. This led Sacks (1984a) to propose that experience is “isolated” (p. 425) in that there are limits of how recipients who receive the teller’s story [cannot feel as the teller who is entitled to feel] feel for ‘an event that has not happened to them personally’.

The distribution of personal experience (i.e. with regard to the teller’s rights and entitlement) and observation within the domain of knowledge is also developed by Labov and Fanshel (1977) when talking about the fundamental classification of knowledge in discourse. According to the authors, there are five categories of knowledge distribution that are related to the [local state of interaction] shared knowledge among the participants involved in the interaction:

Labov & Fanshel (1977, p. 100)

A-events:	known to A (K+), but Not to B (K-)
B-event:	known to B (K+), but Not to A (K-)
AB-events:	known to both A and B (K+)
O-events:	known to everyone present (K+)
D-events:	known to be disputable

Labov and Fanshel (1977) differentiated between A-event (i.e. knowledge possessed by A, but not to B) and B-event (i.e. knowledge possessed by B, but not to A), as when declarative statements made about the ‘B-event’ by A and those made about the ‘A-event’ by B are heard not as asserting epistemic primacy but as soliciting confirmation. In other words, asserting a situation is understood as a request for confirmation when it is reported by a person who has less epistemic authority over a person who has greater epistemic authority (Stivers, et al., 2011). In this case, an inferior epistemic position is conveyed.

Pomerantz (1980), in a similar vein, distinguished between two types of knowledge: Type 1 knowledge and Type 2 knowledge. Type 1 knowables are those that competent subject actors have rights and obligations to know from first-hand experience, (e.g. one’s name, what one is doing or has done, how one is feeling, etc.). Whereas, Type 2 knowables are those that subject actors are assumed to have limited access to by virtue of having heard, seen, having been told or other indirect means (e.g. where is your friend? what did your friend do yesterday?). Pomerantz (1980)



introduced the term “fishing” (p. 188) to refer to a speaker who makes an assertion of a type 2 knowable to elicit information from the recipient’s type 1 regarding a situation, e.g. “saw you drive by last night” (p. 188), “I rang earlier but you were out” , “Yer line’s been busy” (p. 189). Here the speaker reports a situation which she has limited access to: their friend who should have first-hand experience about the situation and who then provides the speaker with an account of why their phone was busy. The speaker, therefore, did the telling in order to solicit more information about ‘Were you talking on the phone and with whom’.

Therefore type 2, according to Pomerantz (1980, p.190) is seen or oriented as limited compared with type 1 which is treated as authoritative as well as insider experience. The witness’s or outsider’s description is treated as a report of an appearance; as evidence. When a speaker as a subject-actor reports an event, he/she tells what he/she knows from his/her experience and his/her inner side. However, knowledge asymmetry might occur in an incongruent epistemic situation, where the interactants disagree over who has greater authority and rights to claim knowledge and report his/her experience. For example, when there is no mutual understanding about the patient’s illness or when the patient who has the primary right to know her illness, or display a knowing and authoritative stance, has not been given the right to speak about her illness, the epistemic asymmetry as well as the incongruent epistemic situations emerge. In this case, the chaperone tends to report the patient’s experience rather than the patient which might lead to the chaperone’s failure to claim epistemic access (see 7.4.2.3).

Sidnell (2012) claims that all languages have various resources that help the speakers to convey to what extent they are ‘certain’ or ‘in doubt’ regarding the knowledge they want to deliver to the recipient. Therefore, when the chaperone is not certain about the information he/she is reporting about the patient’s illness, this means that he/she is in an asymmetrical position of non-entitlement to report patient’s feelings. Therefore, that person is not the authoritative source of knowledge as he/she might claim insufficient or lack of epistemic access to a certain situation (i.e. the patient’s inner feelings).

In order to understand how epistemic asymmetry concerning experience and observation work in three-party medical consultations, it is better to review prior CA research.

### **7.2.2.1. Conversation Analysis research on experience and observation in three-party medical interactions**

Epistemic asymmetry concerning experience and observation in physician-patient-chaperone interaction is a recent research area in CA medical research. While epistemic asymmetry has been investigated in extant research in dyadic medical interaction (Kettunen, 2006; Lehtinen, 2013; Landermark, et al., 2015), there has been no CA research that examines how knowledge asymmetry is managed in three-party medical interactions. Therefore, this study contributes to the CA literature by exploring epistemic asymmetry in three-party medical interaction in Saudi Arabia.

To my knowledge, there is only one recent study that has investigated epistemic asymmetry in three-party medical interaction (Lee & Kim, 2015). Lee & Kim (2015) investigate how epistemic asymmetry is established when presenting a patient's complaint during triage. The data was video-recorded at an academic emergency department in Seoul, Korea. There are different interactional patterns between the patient's own experience and the chaperone's observations. Patients tended to describe the physical conditions they felt and they reported their own subjective experience as a proof of illness that required emergency care. In contrast, chaperones tended to use an objective approach by describing patients' pain extensively. In addition, when speaking about patients' complaints, chaperones did not make claims about their pain as they did not have direct access to this but rather presented the patients' pain as a report of what the patient said (e.g. she said). In other words, chaperones in presenting patient complaints, tended to describe conditions they observed whereas patients describe what they actually feel and have primary access to.

Therefore, two critical remarks are worth mentioning here. First, the literature on knowledge asymmetry in medical interaction has primarily focused on physician-patient relationships (Kettunen, 2006; Landermark, et al., 2015), leaving the impact of the chaperone relatively unexplored. Second, surprisingly there are no observational

studies that show how patient autonomy and primacy is breached by chaperones and physicians in three-party interactions. Therefore, based on the Saudi context where the patient has up until now not given authority or primacy to have access to the knowledge of her illness, the present study represents an initial attempt to tackle the following questions:

### **How is epistemic asymmetry managed in three-party interaction?**

- (a) What are the epistemic resources used by the oncologist and the chaperone to restrict the patient's epistemic primacy and access?
- (b) How are the chaperone's objective observations and the patient's experience constructed in the medical interaction and what are the epistemic resources that the chaperone uses to indicate failure to access the patient's internal feelings?
- (c) How do the oncologist and the chaperone share epistemic access regarding the patient's illness without the patient?

To answer the above mentioned research questions, two single case studies were selected and analysed within the methodological framework offered by conversation analysis. The current study builds on the previous CA research by contributing to the domain of epistemic asymmetry in three-party interaction as well as to the clinical practices in Saudi Arabia.

In the next section, a detailed description regarding the analytical procedures in analysing the two case studies is provided.

## **7.3. Data Analysis Methodology**

### **7.3.1. Case study**

In order to answer the fourth research question in the current research, a case study investigation of the various ways in which epistemic asymmetry is managed in triadic interaction was conducted with reference to two exceptional cases taken from chemotherapy and haematology clinics. Yin (1994) defines the case study approach as “an empirical inquiry that investigates a contemporary phenomenon within its real-life

context, especially when the boundaries between phenomenon and context are not clearly evident” (p. 13). In addition, the case study approach is the appropriate qualitative research strategy which is particularly pertinent to the ‘how’ or ‘why’ questions and right for a situation where the researcher cannot manipulate the behaviours of the participants involved in the study (Yin, 1994).

The merits of selecting a case study as a methodological approach for this chapter are related to different reasons. First, a case study provides a holistic and in-depth investigation of epistemic asymmetry anchored in a real-life clinical context (Yin, 1994). Second, a case design is effective when the issues of the problem under investigation have not previously been examined (i.e. epistemic asymmetry, Saudi cultural norms, oncologist-chaperon non-disclosure). Third, a case study design was used in order to address the research questions about a real-life situation. Fourth, the case study has been used by conversation analysts in medical interaction research to track in detail the various ways in which a certain phenomenon is managed sequentially among participants (Stivers & Heritage, 2001).

Although the case study methodology has positive characteristics as mentioned above, this approach, like any other research methodology, is fraught with criticism owing to the lack of generalisation (Burn & Grove, 2001; Yin, 1994). Therefore, although the two exceptional case studies — selected in this chapter to investigate knowledge asymmetry in Saudi three-party medical interactions — are not representative of the total Saudi Arabia population, they particularly shed light on a practical problem that occurs during medical consultations. The two exceptional cases are among seventeen in which some cancer patients either do not know that they are diagnosed with cancer or do not know which stage of cancer they have reached. By investigating knowledge asymmetry with reference to the two exceptional cases, we hope to give a complete insight into third-party medical consultations in Saudi Arabia. The current chapter represents a negative picture of chaperones’ dominating attitudes in the breaching of the patient’s epistemic right to know her illness in two oncology clinics, unlike in the previous chapters (4, 5, and 6) in which chaperones were seen as playing positive roles during female patients’ medical appointments.

Two case studies were selected for this chapter in order to investigate the epistemic asymmetry in three-party interactions for different purposes. First, chaperones—in both cases two females—are conducting a kind of “epistemic trespassing” (Stivers, et al., 2011), treating themselves as the right person to claim knowledge and to answer for the patients who are treated as less entitled to make claims about their illness. Second, there is no epistemic congruence<sup>82</sup> in which the female patients—who are supposed to have greater epistemic access than their chaperones—are treated as non-autonomous patients and their epistemic status and stance (i.e. turn design and degree of certainty) are highly controlled and dominated by their chaperones and physicians in this context. In this case, the situation is epistemically incongruent. In other words, knowledge asymmetry becomes more difficult for female patients in this context; in which the patients in our data have no right to know the reality of their illness neither to report their illness. Third, the physicians and chaperones take control of the constructed reality of the patient’s illness in a shared language they cannot understand. Therefore, the varying degrees of the inequality in the distribution of knowledge are clearly manifested in the two exceptional or deviant cases that are investigated in this chapter. It is hoped that such exceptional cases will contribute to the literature of epistemic asymmetry by illuminating the patient’s autonomy and primacy regarding the reality of her illness as well as the narration of her illness.

The exceptional cases were chosen during the data collection and the data analysis phases. With regards to the data collection, it was observed in different facets that something strange was happening. First, when asking for consent from both the patient and her chaperone (see difficulties encountered in Chapter 3) to participate in the study, I was informed that the patient had cancer but she had no background knowledge of this. I was also warned not to disclose anything to the patient. Second, when filling in the information sheet with the patient about reasons for the visit, the patient reported symptoms (e.g. stomach-ache) which were different from those I was told about by her chaperone (e.g. tumour in the gallbladder) and observed in the clinic. Third, when observing the oncologist-chaperone’s private conversation, the chaperone

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<sup>82</sup> Epistemic congruence refers not only to agreement on epistemic access but also to agreement on the patient’s epistemic primacy (Stivers, et al., 2011).

was informed that the patient had reached fourth stage cancer which means the patient's chance of survival is limited.

As far as data analysis is concerned, the deviant cases were observed during the preliminary analysis of the data. A recurrent pattern of epistemic fissure was noted that breached the epistemic norms of the patient's primacy and access in medical interactions. Therefore, a decision was made to conduct a case study on two exceptional cases and report these cases as a chapter of this thesis. The two cases examined in this chapter are presented in two extracts (7.2 & 7.3). Each extract begins with the Arabic transliteration followed by the English translation. As shown below, the two extracts (7.2. & 7.3) are presented in detail. First, Extracts 7.2. (i.e. Noura) and 7.3. (i.e. Fatma), show deviation as well as violation of knowledge norms from the start until the end of the consultation in various ways (the chaperone's control, the patient's restricted participation, the chaperone speaking for the patient, the chaperone's insufficient knowledge in claiming patient experience, and the oncologist-chaperone's shared knowledge regarding the cancer diagnosis without the patient). An overview of each case is presented below.

Extract (7.2.) is from the Chemotherapy clinic. The patient, Noura, was 41 years old and had an intermediate school certificate. Noura was accompanied by her illiterate mother who was 60 years old. Noura had been diagnosed with breast cancer and had had one of her breasts removed. She knew about the breast cancer she had had in the past. Now the tumour had spread throughout her body and she had no idea about this. The patient seemed very tired and sick. The attendants in the clinic were: a female oncology specialist<sup>83</sup>, the patient and her chaperone, a female nurse and the researcher.

**Extract 7.2. H3 V 66 D 23 Da. 7/1/2012 Cl. Chemo. (Pt: aged 41, her mother, aged 60)**

- |   |       |                                  |
|---|-------|----------------------------------|
| 1 | F.CH. | <ta ba nah nu rah. >             |
| 2 | Dr.   | o::↓oh                           |
| 3 | Dr.   | ta - ba nah↓ nu r[ah?            |
| 4 | F.CH. | [wal-la::h ma tu::dhu q sh↑ ai = |
| 5 | Dr.   | =↑ ha ash <u>mushkilah?</u>      |

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<sup>83</sup> The male oncology consultant had to leave the clinic before it started as he received an urgent call from the inpatient department.

- 6 (0.1)
- 7 F. CH. ar[sh (.) wa kuhah ma::rah baD-DAQI QAH
- 8 Dr. arSH wa kuHAH?
- 9 F. CH. iywah↓ iywah↓
- 10 Dr. wa aRSH ba ad al-la akil wala bidu n al-LKIL wala ,
- 11 F. CH. ma TA KU::L
- 12 Dr. (.) ma a KU::L ?
- 13 F. CH. ma :: TA KU::L ,
- 14 Dr. bass arish.
- 15 F. CH. [ma ↑takul
- 16 Dr. [inti amaliti ashi ah qalb ma uh
- 17 (0.1)
- 18 Dr: [sawatu ashi ah↑
- 19 F.CH. [tishki tishki minaha=
- 20 Pt: =°ma sawa na ↓°
- 21 Dr. ↑huh ma sawatu ?
- 22 F.CH. iywa::h
- 23 Dr. > akhar tanu im ma sawa tu ashi ah- aq<sup>3</sup>ra s<
- 24 F.CH. la .
- 25 Dr. wa ba di n ish fi ah ta ni ku-h(h)ah=
- 26 F. CH. = adraha hina
- 27 Dr. fi h balgham wala shi ↑
- 28 F. CH. alam alam.
- 29 Dr. alam fia ↑ - dar
- 30 ma fi balgham wala shi ma a kuhah
- 31 F.CH. °mm°
- 32 Dr. bass kuhah↑
- 33 F. CH. iywah↓
- 34 Dr. mhmm
- 35 fi iyy sukhu nah wala shi ? =
- 36 F. CH. =wa ba di n arashat liylat<sup>3</sup> awal- aaa
- 37 arashat dam↓(.) liylat<sup>3</sup> awal
- 38 Dr. arashat dam
- 39 F.CH. liylat<sup>3</sup> awa::l
- 40 Dr. mhmm
- 41 F. CH. arashat dam
- 42 Dr. kum mita mita
- 43 F. CH. liylat<sup>3</sup> awa::l=
- 44 Pt. =bass arashat dam marah wa adah. =
- 45 F.CH. =wa adah. wa adah.
- 46 Dr. hina akhat tanwi m wala fi <sup>3</sup>bai t?
- 47 F.CH. [makhadha::t tanwi m fi <sup>3</sup>bai ::t.
- 48 Pt. [ARRTa at fi <sup>3</sup>bai ::t
- 49 F. CH. fi <sup>3</sup>bai ::t.
- 50 Dr. fi <sup>3</sup>bai t↓ fi <sup>3</sup>bai t.
- ((Ten lines cut))
- 61 Dr. I also need an admission paper. ((Doctor is speaking in English))

62 N. Admission paper?  
63 Dr. Because Nurah is here for admission now.  
64 N. mm.  
65 (0.2) ((the doctor is writing))  
66 Pt. ba anti yuj(h)a ni ↓ ba ANTI .  
67 ((doctor is still writing))  
68 F. CH. tishiki min ba naha  
69 ((the doctor is reading Nurah's file))  
70 (0.27)  
71 Dr. ʔra HA (.) min ʔma RA ↓ anti a raf=  
72 =mushkilah hina fi ʔra HA,=  
73 F. CH. =wa ba anaha ?=  
74 Dr. wa fi ba an kama n, [haza min ʔal ʔmara kama n.  
75 F. CH. [iwah.  
76 Dr. insha l-la h↑ dahi n aktub tanwi m insha l-la h [( )

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1 F. CH. <Nurah↓ is ↑sick>  
2 Dr. o::↓oh  
3 Dr. Are- you sick↓ Noura?  
4 F. CH. I swear to Go::d that she hasn't eaten any↑thing=  
5 Dr. =↑ Okay what's the problem?  
6 (0.1)  
7 F. CH. Vomit[ing (.) and a seve::re cough every MINUTE.  
8 Dr. Vomiting and a cough?  
9 F. CH. yeah↓ yeah↓  
10 Dr. And voMITING after food or without FOOD or,  
11 F. CH. she didn't EA::T  
12 Dr. (.) she didn't n't EA::T?  
13 F. CH. She didn't EA::T,  
14 Dr. Only vomiting,  
15 F.CH: [she didn't ↑ eat  
16 Dr. Have you (sing.) had a heart x-ray?  
17 (0.1)  
18 Dr: [have you (pl.) had an x-ray?  
19 F.CH. [she is complaining she is complaining =  
20 Pt. =°we haven't ↓°  
21 Dr. Huh? You (sing.) haven't?  
22 F. CH. Yea::h.  
23 Dr. >On the last admission you didn't have a heart x-ray<  
24 F.CH. No.  
25 Dr. And is there anything else cou(h)gh =  
26 F. CH. =Her chest here.  
27 Dr. Is there any sputum or anything?  
28 F. CH. Pain pain.  
29 Dr. Pain in ↑ the chest (.)  
30 No sputum nor anything else with the cough?  
31 F.CH. °mm°



32 Dr. Only a cough?  
 33 F. CH. Yeah.  
 34 Dr. Mhmm  
 35 Is there any fever or anything =  
 36 F. CH. =And she vomited last- night -aaa  
 37 She had blood when vomiting↓ (.) the day before yesterday  
 38 Dr. She had blood when vomiting  
 39 F. CH. The day befo::re yesterday  
 40 Dr. Mhmm  
 41 F.CH. She had blood when vomiting  
 42 Dr. How many when when?  
 43 F. CH. The day befo::re yesterday=  
 44 Pt. =I only vomited blood once.=  
 45 F.CH. =Once. Once.  
 46 Dr: Were you admitted here or did you stay at home?  
 47 F. CH. [she wasn't admitted she was only at home↓  
 48 Pt: [I RELAXED at ho:me  
 49 F. CH. at ho::me.  
 50 Dr: at ho::me at ho::me

((ten lines cut))

61 Dr. I also need an admission paper. ((Doctor is speaking in English))  
 62 N. Admission paper?  
 63 Dr. Because Nurah is here for admission now.  
 64 N. Mm.  
 65 (0.2) ((the doctor is writing))  
 66 Pt. My stomach I have ↓ pa(h)in my stomach.  
 67 ((doctor is still writing))  
 68 F. CH. She is complaining about her stomach  
 69 ((the doctor is reading Nurah's file))  
 70 (0.27)  
 71 Dr. The luNG (.) From the disEASE↓ you know=  
 72 =the problem here is in the luNG,=  
 73 F. CH. =and her stomach?=  
 74 Dr. =and the stomach as well, [this is from the disease as well.  
 75 F. CH. [yeah.  
 76 Dr. God willing now I will write an admission in [God's willing ( )

Extract (7.3.) is from the Haematology clinic. The patient, Fatma, was a 65-year old, illiterate, widow accompanied by a 29-year old daughter who had a university education. Fatma is diagnosed with leukaemia and she does not know anything about it. The attendants here were as follows: two oncologists, a consultant (Dr1.) and a resident (Dr2.), Fatma and her chaperone, a Saudi female nurse, and the researcher.

**Extract 7.3. H3 V. 30 D. 14 Da.25/12/2011 Cl. Haem. (Pt: aged 65, her daughter, aged 29)**

- 7 ((the researcher put the audio- recording on the doctor's office))  
8 ((door is closed))  
9 (0.3)  
10 ((the second doctor is opening the patient's file))  
11 ((the consultant is talking to the second doctor))  
12 ((the second doctor is dictating the consultant the patient's file number))  
13 Dr2. wahid afar thalathah thalathah↓  
14 Dr1. aaywah,  
15 (0.3)  
16 Dr2. arba ah sitah thalatah kha::masah↓  
17 ((the consultant is typing into the patient's file on the computer))  
18 Dr1. thalatah khamasah↓  
19 (0.4)  
20 Dr1. ( )  
21 Dr2. a h,(0.2) kam <sup>3</sup>a (.) takhudi kam abah↓ arba aba t↓  
22 F. CH. iywah↓  
23 (0.4)  
24 Dr2: nisyu ma adaha <sup>3</sup>ma ↓ giti sh li ah  
25 <sup>3</sup>marah <sup>3</sup>li fa tit ma dik?  
26 F.CH. ka nat misa ::frah↓  
27 Dr1. → akhudi <sup>3</sup> la q wala la ah  
28 (0.1)  
29 F. CH. iah batakhudu bas imba ri t abat shwaiyyah↓  
30 Dr1. iyyah al-li ta abak?  
31 F. CH. ma adri shakluhu::↓ ( 0.2) y[a a↑ni  
32 Dr1. [ a sah bi ayyah↓  
33 F. CH. ka nat min a - a wa ahiyat↓ asa h wa, (0. 2)  
34 wa asa h shi-yyi ya ani fi shiyyi↓ ( )  
35 fi na[fsaha h  
36 Dr1. [du kha ya ani w[ala a gah  
37 F. CH. [iyi::wah (0.1) du kha  
38 Dr1. ( ) ya mohammad↑ (D1 is calling D2)  
39 (0.5) ( the second resident doctor is looking at the patient's file)  
40 Dr2. huwa maktu b min RBS normal last time but:[a  
41 Dr1. [°normal one°↓  
42 Dr2. But anaemic she was↑ anaemic she was before anaemic↓  
43 (0. 4)  
44 Dr1. ( )  
45 Dr2. taiyyb <sup>3</sup>hi mu - <sup>3</sup> hi mu qlubi kam↑(0.1) ten point seven  
46 Dr2. indik agh ya umi wala SUKAR  
47 F. CH. ° indaha as-suk[ar°↓  
48 Pt. [ indindi as-sukar wa rasiyy↓

49 Dr2. [takhud aliyyaha bu b↑]  
 50 F. CH. °iywah°↓  
 51 Dr1. ai b tita ba as-skar ma a ad-duktu r[ ha↑  
 52 Pt. [ andi sukar wa andi  
 53 abah fi al-liyyal wa abah fi a - abah]  
 54 Dr2. intu min fiyyan↓ intu min fiyyan↓  
 55 F. CH. °min ʔrawabi ↓°

-----  
 7 ((the researcher put the audio- recording on the doctor's office))  
 8 ((door is closed))  
 9 (0.3)  
 10 ((the second doctor is opening the patient's file))  
 11 ((the consultant is talking to the second doctor))  
 12 ((the second doctor is dictating the consultant the patient's file))  
 13 Dr2. One zero three three↓  
 14 Dr1. Yeah,  
 15 (0.3)  
 16 Dr2. Four six three fi::ve↓  
 17 ((the consultant is typing the patient's file into the computer))  
 18 Dr1. Three five ↓  
 19 (0.4)  
 20 Dr1. ( )  
 21 Dr2. erm (0.2) how erm (.) How many tablets do you take↓ four tablets?  
 22 F. CH. Yeah.  
 23 (0.4)  
 24 Dr1. They forgot her appointment↓why didn't  
 25 you come last time your appointment?  
 26 F. CH. she had been a wa::y.  
 27 Dr1. You are taking the medicine or not?  
 28 (0.1)  
 29 F. CH. Yes she is taking it but yesterday she was a little bit sick.  
 30 Dr1. What makes you sick?  
 31 F. CH. I don't know it see::ms↓ (0.2) I [mea↑n  
 32 Dr1. [what do you feel ?  
 33 F. CH. She woke up↓ in the morning she felt and (0.2)  
 34 she felt with some-thing I mean there is something  
 35 in her[self  
 36 Dr1. [dizziness I mean o[r something like that?  
 37 F. CH. [ye::ah (0.1) dizziness  
 38 Dr1. ( ) Oh mohammad↑  
 39 (0.5) ( the second resident doctor is looking at the patient's file)  
 40 Dr2. It's written from RBs normal last time but::[a<sup>84</sup>  
 41 Dr1. [°normal one°↓  
 42 Dr2. But anaemic she was↑ anaemic she was before anaemic↓  
 43 (0.4)

<sup>84</sup> Oncologist is speaking in English.

- 44 Dr1. ( )
- 45 Dr2. Ok how much is the haemo- haemoglobin↑ (0.1) ten point seven ( )
- 46 Dr2. Do you have my mum's blood pressure or DIABETES?
- 47 F. CH. °she has diabetie[s°↓
- 48 Pt. [I have diabetes and headache↓]
- 49 Dr2. [Does she take tablets for that?]
- 50 F. CH. °yeah°↓
- 51 Dr1. Let her check the diabetes with the doctor [ok?
- 52 Pt. [I have diabetes and
- 53 I have one tablet in the evening and a tablet in the morning]
- 54 Dr2. Where are you from ↓ where are you from↓
- 55 F. CH. °from Al-Rawabi ↓°

In terms of analysing the two exceptional cases presented above, CA framework was conducted to explore the epistemic resources by which the patient's epistemic primacy is usurped and her epistemic access is controlled in terms of participation and the amount of information given. In undertaking a conversation analysis of the two deviant cases, a systematic step-by-step guide was followed as described in Chapter 6 (see 6.3.3).

In what follows, I will discuss the CA results of the fourth research question in this thesis.

#### **7.4. Conversation Analysis Results**

In this section, the CA of the final research question of this thesis is discussed. To recap, the research question was:

##### **How is epistemic asymmetry managed in three-party interaction?**

- (a) What are the epistemic resources used by the oncologist and the chaperone to restrict the patient's epistemic primacy and access?
- (b) How are the chaperone's objective observations and the patient's experience constructed in the medical interactions? and what are the epistemic resources that the chaperone uses to indicate failure to access the patient's internal feelings?
- (c) How do the oncologist and the chaperone share epistemic access regarding the patient's illness without the patient?

The results of this question have been presented in three parts. The first part discusses the epistemic resources used by the oncologist and chaperone to restrict the patient's epistemic primacy and access. The second part shows how the chaperone's objective observations and patient's experiences are managed in medical interaction. In addition, the second part covers the epistemic resources that the chaperone uses to indicate a failure to access the patient's internal feelings. In the third part, I explain how the oncologist and chaperone share knowledge regarding the patient's disease in a language that a patient does not know.

Before presenting the results of the above-mentioned research question, it is important to summarise the procedures I followed in discussing the results of this chapter. First, the theme of epistemic asymmetry—which is emerged from the data—is analysed in the light of the above-mentioned extracts. Second, the English translation of each extract is presented only with the extract number appending with the chronological number if an extract is continued from the original, (e.g. 7.2.1 continues from 7.2). Third, the question-response sequence (i.e. adjacency pairs) is the basic unit of sequence organisation (Schegloff & Sacks, 1973) and is the main focus of the analysis.

In the following section, the answer to the first part of the research question is given below with reference to data extracts. In each extract, I illustrate how epistemic norms are violated with reference to the confirmation sequence. I examine the epistemic resources that Noura's and Fatma's chaperones adopted in confirming the doctor's question whether it is addressed to the patient, chaperone, or to the non-selected speaker. I show how asymmetry in knowledge entitlement leads to asymmetry in participation. In other words, I investigate how the physician and the chaperone do not display an orientation towards the patient by giving them the right and the obligation to speak next. In addition, I also investigate how patients' limited participation rights or entitlements (Aronsson, 1991) result in certain types of chaperone control.

### **7.4.1. Epistemic resources used by the oncologist and chaperone to restrict the patient's epistemic primacy and access**

In this section, for various reasons I will focus on the confirmation sequence. First, confirmation sequences are the most recurrent patterns in the data. Second, confirmation is one occasion in which epistemic asymmetry is made relevant, (the confirmed utterance agrees with the relevant next action). Third, there are some cases in my data in which the patient's chaperone gives herself the right and the authority to answer the doctor's diagnostic question even if the doctor addresses the patient directly. Fourth, participants can distinguish between direct and indirect knowledge and can show different levels of certainty (Stivers, et al., 2011).

#### **7.4.1.1. Confirmation sequence**

As mentioned at the beginning of this chapter, the norm in a medical consultation is that when the physician requests information from the patient, it is the patient who presents her problem by describing the physical conditions she feels. By reporting her subjective experience, the patient treats her body as evidence for seeking health care (Robinson & Heritage 2014). However, this norm might not always happen as it is violated by the presence of the chaperone and by the Saudi cultural norms of non-disclosure as seen in the following extract. For instance, Noura's mother is able to assess her daughter's health situation in the light of her observations (e.g., "she hasn't eaten any<sup>↑</sup>thing", (line 4) ; "vomit[ing (.) and a severe cough" (line 7); "she had blood when vomiting" (line 37). The interactional pattern observed in the data has a different sequence of actions: (1) the doctor seeks confirmation via a diagnostic question directed either to the patient, chaperone, or both by using the plural 'you', or no selected speaker is identified, and (2) the chaperone's answer (using minimal token).

There are two types of confirmation used by the chaperone to confirm as well as align with the prior utterance. These are: (1) confirmation with the alignment token 'yeah', (2) confirmation with full repetition. Each type is discussed below with reference to the data.

#### 7.4.1.1.1. Confirmation through the alignment token Yeah

The first epistemic resource<sup>85</sup> used by the chaperone specifically to confirm and align with the doctor's prior turn is the alignment token 'yeah'. As mentioned in Chapter 6, the minimal alignment token occurs in the turn-initial position, where the patient's response is considered enough and needs no further elaboration from the chaperone in confirming the previous utterance. Therefore, the emergent pattern here is that the doctor asks a question directed either to the patient (i.e. by using the patient's name, or pronoun 'you'), or to the chaperone, (i.e. by referring to the patient as 'she', plural 'you', or to a non-selected speaker) and the chaperone responds by using the alignment token 'yeah' as clearly shown in the following extracts:

##### **Extract (7.2.1) (continued from Extract 7.2).**

- 5 Dr. =↑ okay what's the problem?  
6 (0.1)  
7 F. CH. Vomit[ing (.) and a seve::re cough every MINUTE.  
8 Dr. → VomitING and a coUGH?  
9 F. CH. → Yeah↓ yeah.  
10 Dr. And voMITING after food or without FOOD or,

##### **Extract (7.2.2) (continued from Extract 7.2).**

- 27 Dr. Is there any sputum or anything?  
28 F. CH. Pain pain.  
29 Dr. Pain in ↑ the chest (.)  
30 No sputum nor anything else with the cough?  
31 F.CH. °mm°  
32 Dr. → Only a cough?  
33 F. CH. → Yeah.  
34 Dr. Mhmm  
35 Dr. Is there any fever or anything? =

##### **Extract (7.3.1) (continued from Extract 7.3)**

- 16 Dr2. Four six three fi::ve↓  
17 ((the consultant is typing the patient's file in the computer))  
18 Dr1. Three five ↓  
19 (0.4)  
20 Dr1. ( )  
21 Dr2. → Erm (0.2) how erm (.) how many tablets do you take? four tablets?  
22 F. CH. → Yeah.  
23 (0.4)  
24 Dr1. They forgot her appointment↓why didn't

<sup>85</sup> Requesting confirmation from the patient carries a significant issue about the patient's epistemic primacy and status.

### Extract (7.3.2) (continued from Extract 7.3)

46	Dr2.	Do you have my mum's blood pressure or DIABETES?
47	F. CH.	°she has diabetic[s]°.
48	Pt.	[I have diabetes and headache.]
49	Dr2.	→ [Does she take tablets for that?]
50	F. CH.	→ °yeah°.
51	Dr1.	Let her check the diabetes with the doctor [ok?
52	Pt.	[I have diabetes and
53		I have one tablet in the evening and a tablet in the morning.]
54	Dr2.	Where are you from ↓ where are you from?

It can be seen in the above extracts that they share common features. First, the female chaperone provides the SPP (i.e. an answer) to the doctor's FPP (i.e. a medical history-taking question) when this question addresses *the patient*, by using the second person pronoun, 'you' as in Extract (7.3.1, line 21, "erm (0.2) how erm (.) how many tablet do you take ↓ four tablets ↓"), *the chaperone*, as in Extract (7.3.2, line 49, "does she take tablets for that?"), or *to the non-selected speaker* as in (Extract 7.2.1, line 8, "vomiTING and a COUGH?", and Extract 7.2.2, line, 32 "only a cough?"). Second, based on her inferential knowledge, the female chaperone in the SPP, in all four extracts, answers the doctor's confirmation question as she has epistemic access to the patient's illness. The thing that supports this is that there is no gap or delay in the phrases that would suggest the chaperone's lack of knowledge regarding the patient's situation. Third, the alignment token 'yeah', in the four extracts, marks the beginning of a turn which immediately becomes relevant to the doctor's prior question, (e.g., Extract 7.3.2, Dr2. [Does she take tablets for that?], F. CH. °yeah°.). Fourth, in all extracts, the respondents have been asked a yes/no question which makes an affirmative or negative answer relevant. Therefore, the chaperones' answers are aligned with the type of questions the doctors ask. Consequently, their answers provide a minimal, positive and simple 'yeah' answer as a complete turn without any expansion.

The minimal alignment token 'yeah' appears in the history-taking questions in all extracts with the exception of Extract 7.3.1 above. In this extract, the doctor uses the confirmation question as an opening sequence to the consultation after the resident doctor (Dr2) dictates the patient's file number to the consultant (Dr1) followed by a



pause. It is observed here that in forming a confirmation question, the doctor uses two embedded questions: (1) an interrogation question seeking information from the patient regarding the quantity of tablets she has been taking, (erm (0.2) how erm (.) how many tablets do you take?), followed by (2) a confirmation question functioning as a candidate answer, ‘four tablets?’ in such a way that the patient confirms the candidate’s answer (Lee, 2013). Although the patient has primary rights as well as epistemic primacy to respond to the doctor’s confirmation question because she owns her illness, the chaperone violates the rules of the turn-taking system by treating herself as having the entitlement to respond. The chaperone confirms the candidate’s answer by using the alignment token ‘yeah’ to maintain the relevance of the action sequence FPPs.

Maintaining relevance with ‘yeah’ as an alignment token with the following action is clearly shown in Extracts (7.2.1 & 7.2.2), and (7.3.1 & 7.3.2). In these extracts, it is important to note that after the chaperones produce the alignment token, the doctors initiate more specific questions about the situation that have been asked before. For example, in Extract 7.2.1, after the chaperone confirms that the patient has ‘vomiting’ and a ‘cough’ by using the alignment token, ‘yeah’, the doctor asks a more specific alternative question on the ‘vomiting’ symptom without any speaker selection<sup>86</sup>, ‘voMITING after food or without FOOD or’. Similarly, in extract (7.2.2) by confirming the doctor’s specific question, ‘only a cough’, the doctor aligns with the chaperone’s prior turn by using the minimal acknowledgement token ‘mhmm’ followed by a specific question on the symptom, ‘cough’, “is there any fever or anything?”. Likewise, in Extract (7.3.2) on confirming in a low voice using ‘yeah’ that the patient takes tablets for diabetes, the doctor then makes a recommendation to the chaperone for the patient to check the diabetes with a doctor, followed by a confirmation question, (e.g. let her check the diabetes with the doctor [ok?]), which is not followed up by the chaperone in their subsequent turn.

In summary, the alignment token ‘yeah’ is the clearest response to the confirmation question that needs no further elaboration. The ‘yeah’ alignment token appears as a response to a history-taking question as seen in extracts (7.2.1 & 7.2.2), and (7.3.2) or as an opening sequence to the consultation as in Extract 7.3.1. The

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<sup>86</sup> It is implied that the physician addresses the chaperone.

epistemic response that ‘yeah’ conveys is based on the chaperone’s second-hand observation of the patient’s physical complaint. The chaperone not only uses the epistemic resource to confirm the prior turn, by using confirmation with the alignment token ‘yeah’ but also uses full repeat as well to indicate access to the patient’s situation as shown in the following section.

#### 7.4.1.1.2. Confirmation by repetition

Confirming with repetition is another epistemic resource through which the participants treat themselves as having the epistemic access to make the initial claim of something they observed (Stivers, 2005). This can be seen in Extract 7.2.3 below, in which the doctor in his diagnostic question seeks confirmation through a ‘repeat repair initiator’ (i.e. the doctor repeats the chaperone’s prior turn which might indicate some problems for the doctor either in hearing or understanding and inviting the chaperone to repair) (Kitzinger, 2013, p. 250) of what the female chaperone has just said, and then the chaperone initiates repair by confirmation through full repeat of the doctor’s prior question.

#### **Extract 7.2.3 (continued from Extract 7.2) Noura’s case**

10	Dr.	→	And voMITING after food or without FOOD or,
11	F. CH.	→	She doesn’t EA::T
12	Dr.	→	(.) she does n’t EA::T?
13	F. CH.	→	She doe::sn’t EA::T,
14	Dr.		Only <u>vomiting</u> ,
15	F.CH:		[she doesn’t ↑ eat
16	Dr.		[Have you (sing.) had a heart x-ray
17			(0.1)

In the history-taking phase, the doctor initiates an alternative question without speaker selection to specifically focus on the symptom ‘vomiting’ whether it is after or without food in line 10, “and voMITING after food or without FOOD or,”. The female chaperone responds to this by reformulating the doctor’s utterance and making a claim that the patient doesn’t eat in line 11, “she doesn’t EA::T” with a prosody and emphasis on the lexical item ‘EA::T’ and lengthening the vowel ‘a’. After a little pause in the doctor’s turn (line 12), which could have enabled the patient to claim knowledge as she has the primary right to assess herself, the doctor invites the

chaperone to perform a self-initiated repair by confirming and providing the repair solution herself which might indicate some problem in hearing or understanding. In response to the doctor's history-taking confirmation question about the patient's symptoms, (i.e. not eating), the chaperone initiates a self-repair by repeating the prior turn (13) to prove her epistemic access which is based on her objective observation that 'Noura does not eat'. Therefore, both doctors and the chaperone transformed Noura into a non-speaker in that both used the third person 'she' rather than the second person (Aronsson, 1991).

Full repeat is not the only epistemic resource to confirm epistemic access to a certain situation. Launching evidence in the chaperone's next turn is another epistemic resource which is clearly illustrated in the following section.

#### 7.4.1.2. Establishing assessment

Establishing assessment towards a person or discussed situation is another method used by the chaperone who might have some access to the patient's physical health (Heritage & Raymond, 2005; Sidnell, 2012). This occurs when the doctor addresses the patient as a primary speaker and the chaperone intervenes by giving evidence as in Extract, 7.2.4. Noura's mother initiates a fact that is known by her, based on her inferential knowledge, that Noura is sick, line 1. Therefore, the physician's initial turn with the discourse marker, 'o::↓oh', line 2, indexes a change of state' from K- to K+ (Heritage 1984b). Then, the physician designs a Yes-No interrogative (YNI) question which presumes a basic knowledge of asymmetry in which the physician lacks information (K-) about the patient's problem, thus indexing the epistemic priority of the patient 'Noura', as the desired recipient as well as the next speaker to respond, who has sufficient knowledge about her health condition (k+) (Heritage & Raymond, 2012; Sidnell, 2012).

#### **Extract 7.2.4 (continued from Extract 7.2) Noura's case**

- 1 F. CH. <Nurah↓ is ↑sick>
- 2 Dr. o::↓oh
- 3 Dr. →Are- you sick↓ Nour[ah?
- 4 F. CH. → [I swear to Go::d that she hasn't eaten any↑thing=
- 5 Dr. → =↑ okay what's the problem?
- 6 (0.1)

Thus the physician requests confirmation from Noura by using the second person pronoun ‘you’ followed by the patient’s name, ‘Noura’ to confirm whether or not she is sick, line 3. The patient’s chaperone violates the turn-taking system by taking the patient’s turn and speaks for Noura. Thus, Noura’s mother intervenes via an overlap with the doctor’s last turn constructional unit to indirectly confirm by producing a stronger evaluation (I swear to Go::d that she hasn’t eaten anything) than by using a weak evaluation or the same evaluation (Promerantz, 1984) (i.e., of ‘yes’ agreement or no, I’m sick). The use of the discourse marker in the initial position or initial turn, ‘wal-la:h’, i.e. ‘I swear to Go::d’ corroborates and emphasises the chaperone’s assessment and evaluation of the patient’s health condition, ‘sick’ (Opsahl, 2009). The chaperone’s epistemic assessment of Noura’s status is based on her objective as well as her outsider perspective by virtue of having observed her daughter’s health situation (Drew, 1991; Heritage, 2011).

Several observations are evident here. First, Noura’s lack of alignment with the physician’s activity, i.e. requesting confirmation is disaffiliative. In other words, Noura’s disaffiliation stance is displayed implicitly by giving ‘no response’ to the physician’s question (Drew 1991) and explicitly by not supporting her mother’s stance. Second, the chaperone in this context not only takes into account the differential distribution of knowledge but also the differential distribution of the rights and responsibility of knowledge (Heritage & Raymond, 2005). For example, Noura’s mother does not respond with a straightforward confirmation, rather, by appending ‘she hasn’t eaten any<sup>↑</sup>thing=’, to mark her own access based on her inferential knowledge as being a caring mother. Therefore, the chaperone’s certainty is ultimately shaped by swearing to God followed by a description of the observable symptoms, in line 4. Third, the chaperone responds first without giving the patient the epistemic primacy to respond for herself and at the same time violates the rules of the turn-taking system. In this way, the chaperone is constructing a dominant identity for herself (Robinson, 2007). Moreover, the absence of Noura’s response in this extract indicates that Noura is not available for further discussion. Instead, her mother immediately positions herself as a recipient for further speaking making more discussion relevant. Fourth, the epistemic marker, ‘wal-la:h’, (i.e. ‘I swear to Go::d’) emphasises

assessment typically in combination with other features, i.e. describing the patient's health condition.

In summary, the extracts discussed thus far show that the chaperone tends to use various epistemic resources to confirm the physician's prior turn by using the alignment token 'yeah', full repeat, and assessing the evidence. Such evidential or epistemic markings (e.g., I swear to God, vomiting) may reflect the chaperone's degree of certainty and degree of access. Although chaperones in the above extracts breach the patient's rights to respond to the doctor's question, their response design exerts efforts by providing factual evidence based on their objective or exterior observation of the patient's health condition. Therefore, the chaperone's identity is perceived as a caring<sup>87</sup> family member.

Epistemic asymmetry is not only managed through direct confirmation, or establishing assessment, but also by presenting epistemic observation and experience. The results of the second part of the fourth research question in this thesis (i.e. asymmetry in epistemic observation and experience) are discussed in the next section.

#### **7.4.2. Asymmetry in epistemic observation and experience**

Epistemic asymmetry is also managed by chaperones presenting objective observations concerning patients' symptoms and by patients reporting their inner experiences. To recap, the second part of the main research question was:

**How are the chaperone's objective observations and the patient's experience constructed in the medical interaction and what are the epistemic resources that the chaperone might use to indicate failure to access the patient's internal feelings?**

The results of this question are presented in three sections: (1) the chaperone's objective observation, (2) the patient's subjective experience, and (3) the chaperone's failure to claim epistemic access. Each is discussed below with reference to the data.

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<sup>87</sup> See footnote 80 in Chapter 6, p. 168.

#### 7.4.2.1. The chaperone's objective observation

In the doctor's history-taking questions in the extracts below, 'are you sick Noura?' (line 3); 'okay what's the problem?' (line 5); 'and vomiting after food or without food or,' (line 10); 'and is there anything else cou(h)gh' (line 25); 'is there any fever or anything' (line 35) (all from Noura's case, Extract 7.2.5); are you taking the medicine or not? (line 27 in Fatima's case, Extract (7.3.3) the responses received from female chaperones build on the observations of the patient's complaint. The observations demonstrate knowledge by providing a description. For example, in response to the doctor's confirmation question directed at the patient, Noura, 'are you sick Noura?', the female chaperone provides an outside description of an observable symptom, 'I swear to Go::d that she hasn't eaten any↑thing' (line 4). Then, the doctor seeks further information with the question 'okay what's the problem?' (line 5). After a one second gap, Noura's chaperone presents two observable symptoms: vomiting and a severe cough, 'vomit[ing (.) and a seve::re cough every MINUTE', line (7). Evidence is also present in the chaperone's response 'she doesn't eat' line (11) to the doctor's specific question about the occurrence of the 'vomiting' symptom, whether vomiting occurs before or after food; 'and vomiting after food or without food or'.

#### Extract 7.2.5 (continued from Extract 7.2) Noura's case

- 1 F. CH. <Noura↓ is ↑sick>
- 2 Dr. o::↓oh
- 3 Dr. → Are- you sick↓Noura[ah?
- 4 F. CH. → [I swear by Go::d that she hasn't eaten any↑thing=
- 5 Dr. → =↑ okay what's the problem?
- 6 (0.1)
- 7 F. CH. → Vomit[ing (.) and a seve::re cough every MINUTE
- 8 Dr. VomitING and a coUGH?
- 9 F. CH. Yeah↓ yeah↓
- 10 Dr. → And voMITING after the food or without FOOD or,
- 11 F. CH. → She doesn't EA::T
- 12 Dr. (.) she does n't EA::T?
- 13 F. CH. She doe::sn't EA::T,
- 14 Dr. Only vomiting,
- 15 F.CH: [she doesn't ↑ eat
- 16 Dr. [Have you (sing.) had a heart x-ray
- 17 (0.1)
- 18 Dr: [have you (pl.) had x-ray↑
- 19 F.CH. [she is complaining she is complaining =

- 20 Pt. =°we haven't ↓°  
 21 Dr. Huh? you (sing.) haven't?  
 22 F. CH. Yea::h  
 23 Dr. >On the last admission you didn't have a heart x-ray<  
 24 F.CH. No.  
 25 Dr. → And is there anything else cou(h)gh =  
 26 F. CH. → =her chest here  
 27 Dr. Is there any sputum or anything↑  
 28 F. CH. Pain pain.  
 29 Dr. Pain in ↑ the chest (.)  
 30 No sputum nor anything else with the cough  
 31 F.CH. °mm°  
 32 Dr. Only a cough↑  
 33 F. CH. Yeah↓  
 34 Dr. Mhmm  
 35 → Is there any fever or anything ↑ =  
 36 F. CH. → =and she vomited last- night -aaa  
 37 She had a blood vomiting↓ (.) the day before yesterday  
 38 Dr. She had a blood vomiting

**Extract (7.3.3) (continued from Extract 7.3) Fatma's case)**

- 24 Dr1. They forgot her appointment↓why didn't  
 25 You come last time your appointment?  
 26 F. CH. She had been a wa::y↓  
 27 Dr1. → You are taking the medicine or not↑  
 28 (0.1)  
 29 F. CH. → Yes she is taking but yesterday she was a little bit sick↓  
 30 Dr1. What makes you sick?

Likewise, Noura's mother points to Noura's chest to indicate another symptom, 'her chest here', (line 26), as a response to the doctor's confirmation question, 'and is there anything else cou(h)gh' (line 25). Moreover, in claiming and working on the seriousness of the illness, 'blood vomiting', the chaperone in Noura's case employs a variety of 'strategic interactional' evidence to work on the observable symptoms as a response to the doctor's question 'is there any fever or anything' (line 35). The chaperone talks about the patient by using the third person pronoun 'she' then presents the observed symptom '=and she vomited', followed by evidence of its occurrence, 'last- night -aaa' in a cut-off of the talk to initiate a repair to replace 'last-night -aaa' uttered in error into a correct clause (Kitzinger, 2013) 'she had a blood vomiting↓ (.) repeats 'she had a blood vomiting↓ (.) the day before yesterday.' By doing this, Noura's chaperone presented evidence of the blood vomiting's occurrence.

Similarly, in Fatma's case, (Extract 7.3.3), Fatma's daughter responds to the doctor's alternative question addressed to the patient, as to whether the patient is taking the medicine or not, 'are you taking the medicine or not?' (line 27). Fatma's daughter responds by confirming that the patient is taking the medicine and then presents a new symptom, 'yes she is taking it but yesterday she was a little bit sick', (line 29).

In summary, it can be seen that in both extracts when talking about the patient's complaint, both chaperones use (she, her) to marginalise the patient from the interaction. In addition, as a caregiver indicating the seriousness of the problem, both chaperones provide their outsider description of what they observed. Chaperones also provide information about patients' symptoms, (Noura's Extract. 7.2.5, (lines, 4, 7, 11, 26, 36 and 37) medication; Fatma's Extract 7.3.3, line 29). In this case, they maintain the role of responsible caregiver who observes the patient's conditions and reports them to the physician. What is interesting here is that both doctors in Noura's and Fatma's case did not ask the patient to confirm or disconfirm what their chaperone reported. Therefore, they treat their chaperones' observations as an authoritative description.

What is still to be discussed is how the patients' experiences are presented. Thus, in the following section, the patients' presentation of their complaints is provided.

#### **7.4.2.2. The patient's subjective experience**

In terms of reporting the patient's subjective experience, it can be seen that Extracts (7.2.6) and (7.3.4) below share common features. First, both patients, i.e. Noura and Fatma intervene to initiate a repair to expand as well as fill in the missing gaps, enacting their entitlement to participate and by doing so, they are claiming more epistemic authority than the chaperone's limited epistemic access. The patient claims to have the most reliable and subjective knowledge about her illness compared to the chaperone's who merely observes the patient's exterior complaints.

#### **Extract 7.2.6 (continued from Extract 7.2) Noura's case**

41	F.CH.	She had a blood vomiting
42	Dr.	How many when when?
43	F. CH.	The day befo::re yesterday=



- 44 Pt. =I only vomited blood once.=  
 45 F.CH. =once. once.  
 46 Dr: → Have you admitted here or you stayed at home?  
 47 F. CH. → [she hasn't admitted she was only at home.  
 48 Pt: → [I RELAXED at ho:me.  
 49 F. CH. At ho::me.  
 50 Dr. At ho::me, at ho::me.

**Extract (7.3.4) (continued from Extract 7.3) Fatma's case)**

- 45 Dr2. Ok how much is the haemo- haemoglobin<sup>↑</sup> (0.1) ten point seven ( )  
 46 Dr2. Do you have my mum's blood pressure or DIABETES?  
 47 F. CH. → °she has diabetie[s°↓  
 48 Pt. → [I have diabetes and headache↓]  
 49 Dr2. → [Does she take tablets for that↑]  
 50 F. CH. °yeah°↓  
 51 Dr1. → Let her check the diabetes with the doctor [ok?  
 52 Pt. → [I have diabetes and  
 53 → I have one tablet in the evening and a tablet in the morning]  
 54 Dr2. Where are you from ? where are you from?

What is interesting in Extracts (7.2.6) and (7.3.4) here is that both patients present their own illness by adding new information — in overlap with the chaperone or doctor's previous turn — which the chaperones fail to provide. For instance, in Extract (7.2.6, line 48) Noura comments on the chaperone's last Turn Constructional Unit, 'i.e. home' by adding 'RELAXED' in emphasis, which loudly functions as an account that means that Noura did something about the situation. In other words, Noura clarifies the chaperone's previous turn by adding the lexical item 'RELAXED' as a linguistic feature that carries a significant meaning that Noura did something at home.

Likewise, in extract (7.3.4) the patient firstly reports her experience in overlap with the chaperone's previous turn, 'she has diabetes' (line 47), by adding a new symptom, 'headache' in line 48, 'I have diabetes and headache'. It is observed that the patient has not received any acknowledgement from the doctor but rather the doctor addresses the chaperone in the next turn as the eligible speaker, in line 49, 'Does she take tablets for that'.

Similarly, what is interesting in Extract (7.2.6) is that there are two questions in turn in line 42, 'how many when when?' addressed by the doctor to the chaperone who is seeking further information about the blood vomiting. In response to this both the

chaperone and the patient divide the task to answer the two questions differently from the order in which they have been constructed in the doctor's question 'how many when when?' First, the chaperone starts by answering the last question, 'when when', as the most contiguous question should be answered first (Sacks, 1987). The chaperone's answer is based on her observation in line 43, 'the day befo::re yesterday'. By contrast, the patient starts by answering the less contiguous question, 'how many' which is based on her epistemic experience, line 44, '=I only vomited blood once.='. Both participants answer both questions in reverse order according to each one's observation and experience.

A second common feature among the two extracts is the use of the personal reference, 'ana ' (i.e. I). That is to say, entitlement is embodied in the reported experience by using the reference pronoun "'ana ' that expresses the experience's ownership, as clearly shown in patients' utterances, 'I RELAXED at ho:me, (Extract 7.2.6, line 48); 'I only vomited blood once', (in Extract line 44); and '[I have diabetes and headache', (Extract 7.3.4, line 52-53); and '[I have diabetes and I have one tablet in the evening and a tablet in the morning]'. It is observed that in extract (7.3.4) after the patient claims her epistemic experience, she has not received any acknowledgment from the doctor. For example, when the resident doctor seeks confirmation from the chaperone as to whether the patient takes tablets for diabetes, in line 49, 'does she take tablets for that', the chaperone confirms by using the alignment token 'yeah' in a quiet voice, in line 50. However, the patient's experiential report comes late in line 52 and 53 and in overlap with the doctor's previous turn, 'I have diabetes and I have one tablet in the evening and a tablet in the morning'. The chaperone's 'yeah' is not enough, so the patient's sufficient knowledge is based on her factual experience.

Other properties shared between Extracts (7.2.6) and (7.3.4) are that the next speaker selection is the patient. For example, although the oncologist addresses the patient in few cases to be the next speaker by using the second singular person pronoun 'you' in Extract (7.2.6) (line 46 'have you admitted here or stayed at home' and a politely addressed term, 'my mum' in extract (7.3.4), (line 46) 'do you have my mum blood pressure or diabetes', the chaperone takes the patient's turn to respond to the doctor's previous question.

In summary, by reporting subjective experience, patients assert their primary right by filling the gaps to which their chaperones do not know the answers. Patients employ reference pronoun ‘ana ’ (I) to characterise their ownership of epistemic illness. However, in certain situations the chaperone claims insufficient knowledge, so she might use epistemic resources to indicate their failure to access the patient’s internal feelings.

Therefore, the following section discusses how the chaperone’s insufficient knowledge as well as her vulnerability of a description (Whalen & Zimmerman, 1990: 472) (i.e. the chaperone’s weak position) leads to epistemic failure regarding a situation that has been asked about.

### 7.4.2.3. Failure to claim epistemic access

Claiming insufficient epistemic access also occurs in three-party medical interaction. In the following extract, the consultant directs a question to the patient using the pronoun ‘you’ about whether she takes the medicine or not, line 27. As the patient does not align with the consultant’s prior turn, the chaperone intervenes after one second (line 28) to confirm that her mother is taking the medicine and then initiates a new topic that her mother was sick yesterday, line 29 (yes she is taking but yesterday she was a little bit sick↓).

#### Extract (7.3.5) (continued from Extract 7.3) Fatma’s case)

- 24 Dr1. They forgot her appointment↓why didn’t  
 25 You come last time for your appointment?  
 26 F. CH. She had been a wa::y↓  
 27 Dr1. You are taking the medicine or not?  
 28 (0.1)  
 29 F. CH. Yes she is taking but yesterday she was a little bit sick.  
 30 Dr1. What makes you sick?  
 31 F. CH. → I don’t know it see::ms↓ (0.2) I [mea↑n  
 32 Dr1. [what do you feel?  
 33 F. CH. → She woke up↓ in the morning she felt and (0.2)  
 34 She felt some-thing I mean there is something  
 35 in her[self  
 36 Dr1. [is it dizziness o[r something like that?  
 37 F. CH. → [ye::ah (0.1) dizziness.  
 38 Dr1. ( ) oh mohammad↑

This invites the consultant to ask a further question on the chaperone's last turn construction unit (sick), by seeking more information directly relevant to the patient, and by using the second person pronoun 'you', regarding the unknown thing that makes her sick, line 30. Again, the chaperone takes over the patient's turn by selecting herself to respond on behalf of the patient. Therefore, the chaperone's response, to the doctor's question from the outset, is designed as dispreferred action (Pomerantz, 1984; Sacks, 1987). Thus, the dispreferred second pair part (SPP) is constructed by indexing the turn-initial 'I don't know' which indicates difficulty in answering the question or claiming insufficient knowledge, followed by epistemic downgrading of the parenthetical verb, 'it see::ms', a two second delay, and then, self-initiated repair 'y[a a↑ni ' (i.e. I mean), which has a pragmatic function of repairing as well as clarifying, elaborating or expanding what has been said before (Al-Harabsheh, 2015). Here, the chaperone's (K-) epistemic status invites the consultant to request more information (as the chaperone's statement 'I don't know' is regarded as incomplete) from the patient herself (for the second time), line 32, about what she feels (line 32) in an overlap with the chaperone's previous turn. The chaperone takes her mother's turn, for the fourth time, describing her observation regarding her mother's state of health. She reports that her mum woke up in the morning, then 'she felt' and then a gap of two seconds is followed by repetition of 'she felt' followed by cutting off the conversation with 'some-thing' and replacing this with another self-initiated repair 'I mean' and then she reformulates, 'there is something in her[self'. All this indicates the chaperone's trouble in accessing her mother's inner feelings (lines 33-35). The consultant, then, through overlap provides the chaperone with a candidate answer (line 36) "is it dizziness or something like that" seeking confirmation. The chaperone, in line 37, confirms by using the alignment token 'yeah', followed by a second gap then another confirmation by repeating the physician's candidate answer, 'dizziness'. What is interesting here is that the patient is marginalised from the conversation because of her non-aligned responses to the consultant's history-taking questions. Therefore, the consultant uses the chaperone as the available respondent for further discussion.

The final point about the asymmetry which emerges and is achieved sequentially through the oncologist's history taking question is that the physician does not question the patient, who is the authoritative source of knowledge, he only relies on the

chaperone's second-hand knowledge. He might have simply asked the patient back in line 38, 'do you feel dizziness?' Although the oncologist is assisting the chaperone, he did not ask the patient to confirm whether or not they had dizziness. Thus, the absence of remedial work by the physician and chaperone is a further way in which the asymmetry is sequentially managed in conversation (Drew, 1991).

To sum up, the chaperone's unequal access to knowledge puts her in an asymmetrical status as well as in a weak position to the extent that there is a body of evidence regarding the patient's inner experience which is not available to the chaperone to employ on behalf of the patient. Rather, she employs knowledge resources to claim insufficient access regarding the patient's feelings. Therefore, epistemic asymmetry does not only occur when chaperones claim no epistemic access regarding patients' bodies but also when patients do not have epistemic primacy and access to the illness they have. In the following section, I will discuss the results of the third part of the main research question in this chapter.

#### **7.4.3. Oncologist-chaperone shared knowledge of non-disclosure of cancer diagnosis**

In this section, I will discuss how oncologist-chaperone mutual knowledge of non-disclosure of cancer diagnosis is managed on clinical visits. To review, the third part of the main research question was:

##### **How do the oncologist and the chaperone share epistemic access about the patient's illness without the patient?**

In the presence of cancer patients both physicians and chaperones collaboratively use linguistic devices to avoid cancer terminology in front of the patients as well as to maintain and establish shared knowledge. In Extract (7.2.7) below, as the consultation reaches a close, the oncologist asks the nurse for an admission paper to request admission for Noura. While the oncologist is writing the admission for her, Noura initiates a symptom-problem "my stomach I have ↓ pa(h)in my stomach." (line 66). The doctor does not acknowledge this (line 67). The female chaperone aligns and

supports Noura by speaking for her, reiterating what she has just said ‘she is complaining about her stomach’ (line 68).

### **Extract 7.2.7 (continued from Extract 7.2) Noura’s case**

- 61 Dr. I need an admission paper also.  
62 N. Admission paper?  
63 Dr. Because Noura is for admission now.  
64 N. Mm.  
65 (0.2) ((the doctor is writing))  
66 Pt. My stomach I have ↓ pa(h)in my stomach.  
67 ((doctor is still writing))  
68 F. CH. She is complaining of her stomach  
69 ((the doctor is reading Noura’s file))  
70 (0.27)  
71 Dr. → The luNG (.) from the disEASE↓ you know=  
72 → =the problem here is in the luNG,=  
73 F. CH. → =and her stomach?=  
74 Dr. → =and the stomach as well, [this is from the disease as well.  
75 F. CH. → [yeah.  
76 Dr. God willing now I will write an admission in [God willing ( )

The chaperone, here, provokes the doctor to take the next action (line 68), i.e. by asking further questions on how and when Noura has been suffering from stomach pain, but the female doctor again does not acknowledge this as she is busy reading the patient’s file (line 69). After a long pause (line 70), the oncologist focuses on a new diagnostic problem, ‘the lungs’ instead of dealing with the patient’s complaint, i.e. pain in the stomach’. In response to the chaperone’s previous turn ‘she is complaining of her stomach’ (line 68), the oncologist uses various linguistic features to display shared knowledge with Noura’s mother about Noura’s cancer diagnosis. I will explain these features turn-by-turn.

First, the oncologist’s turn “The luNG (.) from the disEASE↓ you know=” (line 71) carries different linguistic features. These are: (1) the oncologist makes a link between the problem in the lung with the main factor ‘from the disEASE↓’ (i.e. tumour) which portrays a specific-general account as recognisable shared knowledge (Stokoe, 2012; Widdicombe, 2016), (2) the use of the definite article, ‘the’ here before ‘lung’ and before ‘disease’ indicates that both parties, (i.e. doctor and chaperone) share the same knowledge which the patient does not have, (3) the use of a common

knowledge component 'you know' is a confirmation that both participants, i.e. doctor and chaperone, know the patient's problem. In other words, the use of 'you know' here has specific characteristics which indicate that the information given by the physician is shared by the co-participants and is not new. These characteristics are: (a) 'You know' gives background information about the previous problematic item, namely the fact that the patient's pain in her lung is from the disease, (line 71); and (b) it is directly addressed to the chaperone by using the second person pronoun 'you' in 'you know' who has joint access to this claim.

Second, the expansion produced in line 72 by the oncologist's turn, "the problem here is in the luNG" comes as the assertion latched to the oncologist's previous utterance, (line 71). This indicates that the tumour spread to the lung although the oncologist does not explicitly say it.

Third, the patient's chaperone seeks confirmation from the oncologist as to whether or not the pain in Noura's stomach is from the disease "and her stomach?=" (line 73). It might be that the chaperone here uses the conjunction 'and' to connect clauses together, as a way of demonstrating her shared knowledge with the doctor on one hand and to remind the oncologist of Noura's main complaint, "pa(h)in my stomach" which was mentioned by Noura (line 66) (Eder, 1988; Lerner, 1992).

Fourth, in the oncologist's immediate and latch response, "and in the stomach as well, [this is from the disease as well" (line 74), the doctor confirms by repeating, that the problem is in the stomach as well, followed by a confirmation that the pain in the stomach is from the disease. Such confirmation and clarification trajectories move from specific ('the stomach', 'the lung') to general, (the disease') which also indicates that the tumour has spread to both the stomach and lung.

Fifth, other linguistic features that indicate shared knowledge are: (a) the definite article 'the' in 'the disease' (lines 71 & 74), 'the lung' (lines 71 & 72), 'the problem' (71), 'the stomach' (line 74); (b) the co-occurrence of 'as well' (line 74); and (c) the repetition of certain lexical items that indicate a shared knowledge, 'the disease' (lines 71 & 74), 'the lung' (lines 71 & 72), 'as well' (line 74).

The chaperone then displays agreement by aligning with the oncologist's previous turn in line (75). The oncologist moves to close the consultation by writing an admission for Noura (line 76).

In summary, both the oncologist and the chaperone use different linguistic features to display shared knowledge about the patient's cancer diagnosis. The linguistic features are: (1) the use of definite article 'the', (2) the common knowledge component 'you know' (3) sharing the knowledge with the chaperone by moving from specific to general, and (4) the repetition of some lexical items to indicate a shared knowledge between the oncologist and the chaperone, 'the disease', 'the lung', and 'as well'.

## **7.5. Summary**

In this chapter, I have reviewed CA research regarding the norms of knowledge and norms of reporting self-experience and observation. In data analysis methodology, I have presented two exceptional cases from chemotherapy (i.e. Noura) and haematology (i.e. Fatma) clinics. I have chosen these cases because they represent a clear example of breaching the epistemic norms of three-party medical interactions, particularly patient's primacy and access. I have also mentioned that knowledge asymmetry becomes more difficult for patients in this context; in which the patients (Noura and Fatma) in my data have no right to know the reality of their illness neither to report their illness. In discussing how epistemic asymmetry is managed in three-party interactions, I have shown that epistemic asymmetry is managed through (1) using epistemic resources, (2) presenting observation and experience, and (3) sharing knowledge of cancer non-disclosure.

Concerning epistemic resources, I have reported that both Noura's and Fatma's chaperones used various epistemic markings in order to confirm the physician's prior turn by using the alignment token, 'yeah', full repeat, and assessing the evidence. I have shown that chaperones breached the epistemic norms as well as patients' rights by responding to the doctor's questions even if they were directed at the patient. In speaking for the patient, chaperones tended to provide factual evidence based on their exterior observations.

With regards to observation and experience, I have shown how Noura's and Fatma's chaperones describe their observations regarding patients' symptoms and medications. In presenting patients' complaints, I have demonstrated that both chaperones in Extracts (7.2.5) and (7.3.3) tended to give an outside description of the



patients' complaints with reference to the patient as 'she, or her'. Such references to the patient have a great impact on their marginalisation from the interaction. In contrast, I have found that both patients report their subjective experiences as shown in Extracts 7.2.6 and 7.3.4 by intervening to repair and fill in the gaps in the information which the chaperones fail to claim access to. What is interesting in both extracts, is that when the chaperone presents her observations regarding the patients' complaints, both the oncologists do not ask the patient to confirm or disconfirm what the chaperones said but rather the oncologist addresses the chaperone in the following turn as the eligible speaker (see Extract 7.3.4. lines 49 and 51). This suggests that the physicians should ask the patients whether or not they agree with what their chaperones said or if they had anything to add. However, I have found that the chaperone is not always an eligible speaker as she fails to claim access to the patient's experience.

In claiming insufficient knowledge regarding patients' experiences, I have shown in Extract 7.3.5 how the chaperone lacks sufficient access when describing patients' inner feelings or experiences. I have mentioned that chaperones employ epistemic resources (e.g. 'I don't know', 'it seems', delayed response, hesitation, and repetition) that indicate their weak position in accessing patients' experiences as well as their dispreferred responses. This finding has different suggestions: (1) physicians should listen to the patient reporting their illness experience and not to their chaperones, particularly if the patients are cognitively competent; (2) physicians should speak directly to the patients as they are the ones who have the right to know the diagnosis of their illness and to check their understanding of it, and to be informed about their treatment plan; (3) physicians and chaperones should work together with the patients and clearly explain the actual diagnosis of their illness and support them during their illness by assisting with a treatment plan. All these suggestions would improve cancer patients' care and identify their needs.

With regards to epistemic asymmetry of oncologist-chaperone shared knowledge, I have shown that both participants used various linguistic devices to display shared knowledge regarding patients' cancer diagnosis. I have mentioned that these resources are: (1) the use of the common knowledge component 'you know', the repetition the lexical item 'disease', (2) the use of the definite article 'the' before

certain lexical items to demonstrate shared knowledge (e.g. the problem, the disease, the lung), and (3) moving from specific (e.g. lung, stomach) to general (disease) indicating implicitly that the cause of the pain in the stomach and lung means the spread of the tumour. Such epistemic asymmetry of shared knowledge about cancer diagnosis is a clear example of violating patients' epistemic primacy regarding the reality of their illness. The reason for using shared language between the oncologist and the chaperone—that the patient does not understand—is to protect the patients from bad news and anxiety. This suggests that non-disclosure of cancer diagnosis is still considered to be a major problem for oncologists and chaperones in Saudi Arabia.

Noura's and Fatma's cases are two of 17 cases in which the patients have only partial knowledge about their illness. Some know they have a tumour but they do not know that they have reached fourth stage cancer. Others do not even know that they have been diagnosed with cancer. Although the current chapter is only based on two case studies, these studies are really important in calling for policy intervention regarding patient autonomy in Saudi Arabia as there are another 17 cases who do not know the reality of their illness. It is hoped that the violation of epistemic norms in Noura's and Fatma's cases could eventually encourage the Ministry of Health in Saudi Arabia to develop policy actions regarding patient autonomy in medical settings. Such clinical implications will be discussed in the following chapter.

In Chapter 8, I will summarise the main findings of the current thesis with reference to the aforementioned four research areas, i.e. patient satisfaction, patient perception, alignment and knowledge asymmetry. I will evaluate the quality of the mixed methods used in this study and in what way the quantitative and the qualitative results converge and diverge. I will also discuss the limitations, contributions of the current research and recommendations for future research.

# **CHAPTER 8**

## **Discussion and Conclusion**

### **8.1. Introduction**

In the final chapter of the thesis, I first summarise the central findings that have emerged from this project with reference to the four research areas: patient satisfaction, patient perception, alignment and knowledge asymmetry (section 8.2). Then, I integrate the findings obtained from each and I explain the way in which the quantitative and the qualitative results converge and diverge (section 8.3). I evaluate the quality of mixed methods used in this study (section 8.4) with reference to the limitations of each method. I discuss the various contributions of this thesis to conversation analysis and thematic analysis literature, as well as to clinical practices (of physicians and chaperones) and to higher authorities in Saudi Arabia (section 8.5). I end this chapter by suggesting possible topics for future research (section 8.6).

### **8.2. Summary of main analytic findings**

This section comprises a brief discussion of the findings of this study regarding four main themes: patient satisfaction, patients' perceptions, along with how three-party interactions are practised in reality with reference to alignment and epistemic asymmetry. I will discuss the findings of each theme in turn in relation to previous literature.

#### **8.2.1. Patient satisfaction with three-party interaction**

I have examined (see Chapter 4) the effect of the patient's age, their level of education, and the chaperone's gender on patient satisfaction with (1) overall care; (2) chaperone care; and (3) chaperone involvement. The study participants consisted of 108 female patients (92.3%) who completed a post-visit questionnaire after an audio-

recorded consultation in three hospitals in Jeddah, Saudi Arabia. The majority of the patients had been diagnosed with cancer.

Findings indicated that only patients' education has a significant effect on their satisfaction with their chaperone's involvement (see Table 7). Patients with secondary and postgraduate education were satisfied with their chaperone involvement more than patients with elementary and intermediate education. It could be that some female patients feel shy discussing intimate subjects with their male physicians, particularly if there are more than two in the consultation room. It was observed that patients with male chaperones have a higher level of education than patients with female chaperones. Therefore, it could be that their male chaperones have explicitly said to them 'do not talk to male physicians'<sup>88</sup> and the female patients accept that their chaperones might attend the clinics as surrogate patients.

My findings differ from prior quantitative research (Street & Gordon, 2008), which indicated no significant effect of patients' level of education on patient satisfaction with chaperone involvement. This finding could be explained by the fact that a quarter of the female patients in the current study had secondary and higher levels of education whereas in Street's and Gordon's (2008) study nearly half of the patients only had some college education. This might be explained by the cultural differences in which the educated patients in Street's and Gordon's (2008) study were geriatric male cancer patients who were able to interact with physicians without the need for chaperone involvement. However, patients in the current study are females from a wide range of age groups who might need their chaperones to interact with their male physicians on their behalf.

In summary, the effect of patients' education on their satisfaction with chaperones involvement was validated by asking the Saudi female patients their perceptions regarding their chaperones' attitudes during their medical appointments. Findings of the thematic analysis of the patients' perceptions are shown in the

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<sup>88</sup> This is one of the negative effects of a chaperone's presence. Some well-educated female patients reported that their male chaperones warn them not to talk to the male physicians and instead they (the chaperones) will interact with them on behalf of the patients.

following section. The qualitative findings are used to complement the quantitative results.

### **8.2.2. Patients perceptions of chaperones' roles and gender variation**

In Chapter Five, I have explored the Saudi female patients' perceptions regarding their chaperones' roles during their medical visits and gender variations in the supportive roles chaperones fulfil when caring for their sick relatives. A thematic analysis of the open-ended questions resulted in the identification of three main themes that clarified chaperones' roles (see Figure 6) and gender variation (see Table 10). Findings yielded by this study showed that female patients perceived their chaperones as essential in fulfilling three supportive roles. The female patients rated the provision of emotional support as the most significant. Emotional support, according to them, was a feeling of psychological comfort and security because of the physical presence of a comforting chaperone during their medical encounter, as well as the verbal support the chaperone offered during their suffering. The rationale behind rating emotional support as the most important could be that Saudi female patients have traditionally been the source of emotional support for their family and might expect the same support when they are ill and rely on others (Katooa, 2014; Suliman, et al., 2009). In addition, because the majority of the study participants were cancer patients, many of whom have lost hope and felt angry and helpless, they turned to their chaperones for emotional support. Therefore, they may need their family to boost their spirits and self-esteem, and alleviate their distress and pain, as well as give them the feeling that they are beside them no matter what is needed. The significance that the study participants assigned to their chaperone's emotional support is in line with the findings of prior research, such as Beisecker et al., (1996) and Northouse (1981). Northouse (1981) found that the presence of a supportive chaperone within the patient's social support system, and in particular during the medical visit, comforted and reassured the patient, and made her feel more at ease and more determined to cope with the illness. Similarly, the patients in Beisecker et al.'s (1997) study rated chaperones' emotional support role as very important to them. However, they failed to indicate the reasons behind considering support and companionship as the most important aspect of this role.

When differences in the roles played by male and female chaperones were examined, it was evident that the latter was more valued for their emotional support. The supportive emotional role played by the female chaperones in the current study appears to be very similar to those reported in previous observational (Ellingson, 2002) and mixed method studies (Beisecker & Moore, 1994). Physicians in Beisecker & Moore's (1994) study characterised female chaperones as being "keyed into emotional support and expressing care" (p. 35).

The second theme that emerged from the analysis of patients' perceptions was informational support. The study participants rated informational assistance as the second most important support method their chaperones offered. This finding seems consistent with the results reported by Beisecker et al. (1997). The female patients in the current study reported that their chaperones would typically advocate for them and remind them of important facts. In terms of the advocacy and memory aid roles, the chaperones supported the patients verbally and cognitively by speaking for them. Some patients in the current study preferred their male chaperones to speak on their behalf and discuss intimate subjects with their male physicians for them. However, other patients preferred their female chaperones to speak for them because of their poor literacy and because they thought that they could not express themselves well because of being uneducated. When these roles were examined in terms of the chaperone's gender, there was no significant difference between males and females in terms of readiness to speak for the patients.

In terms of gender differences in providing informational support, findings have shown that both genders were equally likely to be active in their advocacy role, particularly when it came to talking on the patient's behalf. This finding does not support the conclusions of several studies about three-party medical interactions (Badreldin, 2011; Clayman et al., 2005). For example, Badreldin (2011) claimed that, when a Saudi male chaperone accompanied his female relative, he talked on the patient's behalf. However, in investigating gender variation in three-party medical interactions, Clayman et al., (2005) found that female chaperones are more verbally active and expressive than their male counterparts. The divergence of these findings could potentially mean that some patients may prefer to have the chaperone as the main speaker in the interaction. Moreover, with about half of male chaperones in this

study serving as a memory aid for the patients, they were more active in this role than their female counterparts. This finding contradicts the results reported by Ellingson (2002), who found that female chaperones were usually the memory aid for their sick male relatives. The differences in the findings might be due to the data collection method, because Ellingson (2002) conducted an observational study only as opposed to the current thesis. Thus, as direct reports from patients regarding their experiences with chaperones' roles were not sought in Ellingson's study, it is possible that the researcher's perceptions differed from those of the participants. In contrast, the present study relied on direct reports from the patients, thus identifying the roles that are important to them from their perspectives.

Additionally, although Ellingson did not clearly mention the gender of patients who participated in her study, she stated that memory aid was specifically apparent among male patients, who sought the help of their wives regarding medical information. This too could be a source of differences, as the participants in this study were female patients.

The third theme yielded by the analysis of the participants' responses was logistic support. Patients reported that their chaperones fulfilled two caring tasks: (1) providing transport and (2) physical assistance. Providing transport, according to the patients in this study, was the support they clearly needed, as women are not allowed to drive in Saudi Arabia. However, although essential, this point was not as important as the emotional support required. This finding supports the results provided by the study conducted by Beisecker, et al. (1997), in which the participating cancer patients rated providing transport as less important than informational support. However, in other studies (Glasser, et al., 2001; Prohaska & Glasser, 1996; Wolff & Roter, 2008), participants rated the provision of transport as the most important reason for a chaperone's attendance at a medical appointment. This discrepancy could be due to the difference in the population studied. More specifically, the majority of the patients in prior quantitative research were geriatrics, who may have stopped driving at some point, or may have been vulnerable or in poor health and therefore felt the need for more physical support from their chaperones.

In contrast, the majority of patients who took part in the current study were cancer patients from different age groups.

With regards to physical assistance, patients reported that their chaperones made their appointments for them and assisted them with dressing. Although patients in previous research (Prohaska & Glasser, 1996; Prohaska, et al., 2001) rated general assistance less important compared to providing transport, they failed to specify the kind of assistance their chaperones provided. Only a few patients in Wolff and Roter's (2008) study specifically mentioned scheduling appointments. In the current research, however, patients did not limit their experiences to the physical support they received from their chaperones during their medical encounters (e.g., making appointments). In their narratives, they also mentioned the support they received beyond the medical visit (i.e. at home, for example, help with dressing or changing the patient). These results differ from those yielded by Prohaska and Glasser's study (1996), where the majority of older patients made their own appointments while the Saudi female patients that took part in the current study received assistance from their chaperones in this respect.

With regard to gender differences in the style and level of logistic support provided by the chaperones, patients' perceptions indicated that the provision of transport from their male chaperones was a cultural necessity. Thus, this was an important aspect of the chaperone's role, which could only be fulfilled by males. This finding diverges from the results of past studies conducted in other countries, where female chaperones could also provide transport for their sick relatives (Navaie-Walliser et al., 2002). On the other hand, female chaperones were more active than their male counterparts in assisting the patients physically by making appointments and dressing them. These findings support the conclusions of Navaie-Walliser, et al.'s (2002) comparative analytical study regarding gender differences in caring for sick relatives. The authors found that female chaperones are the primary caregivers and usually provide their relatives with the more instrumental activities of daily living such as transport.

Thematic analysis of the open-ended questions is validated in the real life three-party medical context. The conversation analysis findings of the audio-recorded data are presented below.



### **8.2.3. Alignment in three-party consultations**

I have investigated (see Chapter 6) how alignment occurs in three-party medical interactions. Findings yielded by the current study showed that the alignment that developed during three-party medical interactions in which a female patient was accompanied by a chaperone was achieved via multiple structurally organised actions that are ordered logically and effectively coordinated with prior action. This represented a set of norms, which are intersubjectively understood and linked to participants' understanding of these rules. Conversation analysis of alignment formation in three-party medical interactions demonstrates three main patterns of alignment: (1) doctor-patient; (2) chaperone-patient (and patient-chaperone), and (3) chaperone-doctor (and chaperone-patient) alignments. Findings reported here indicate that, in the first pattern, i.e. doctor-patient, alignment occurs when the doctor requests confirmation or information from the patient by addressing the question to the patient using an address term or the second person pronoun. In response to that, the patient aligns with the doctor by using confirmation or expansion. In the second type of alignment, chaperone-patient alignment, alignment emerges from four important practices, i.e. confirmation (using minimal alignment token) (see Extracts 6.8 and 6.9), confirmation by repetition (see Extracts 6.10 and 6.11), expansion (see Extracts 6.12 and 6.13), and turn-completion (see Extracts 6.14 and 6.15). This finding supports the conclusions of several previous studies (Ellingson, 2002; Hamilton, 2013). Ellingson (2002) found that chaperones take a very active role in forming alignment either with the patient or with the physician for the sake of confirmation, expansion, or aiding decision-making. Such successful alignment reveals the “synergistic style” (Ellingson, 2002, p. 377) between the chaperone and the patient. Both chaperone and patient synergistically align in order to proceed in their active roles and achieve the goals of the visit. Such successful alignment between the chaperone and the patient is based on demonstrating that the chaperone is highly involved in the familial relationship (Boehmer & Clark, 2001).

The third type of alignment is chaperone-doctor (and chaperone-patient) alignments, in which the chaperone reiterates what the physician wants the patient to do regarding the treatment plan (see Extract 6.17). All these actions indicate that the participants are collaboratively involved in positive interaction which enhances patient

participation. Patient participation in this study is the result of the physician's selection practices aimed at establishing who has the primary authority to present the problem, as reported in previous studies (Stivers, 2001).

The results of this study also reveal the presence of a strong connection between chaperones' roles and the types of alignment that participants form during a triadic medical visit. In an earlier study, Adelman et al. (1987) found a strong correlation between the chaperone's institutional role and the type of alignment he/she formed during the consultation. For example, in chaperone-patient alignment, the chaperone played an advocate role, i.e. that of the patient's promoter (supporting the patient's agenda) and patient's extender (providing supplemental information). In addition, in chaperone-physician alignment, the chaperone played the role of physician-patient mediator, whereby he/she reiterated what the physician reported in order to aid the patient in making a decision regarding the proposed treatment. The present study shows evidence of both alignment types. The presence of chaperone-physician alignment in the analysed consultations supports the conclusions of several studies (Boehmer & Clark, 2001; Clayman, et al., 2005; Ellingson, 2002). For example, Ellingson (2002) found that the chaperone aligns with the physician in order to repeat what the physician has said for the patient, as well as re-clarify details of the treatment plan to help the patient make the decision regarding the treatment plan.

As far as gender variation is concerned, it has been found (in Chapter 6) that male chaperones aligned with patients and physicians more than their female counterparts whether by counting the frequency of alignment by consultation (see Table 12) or by the total number of instances across the data between male and female chaperones (see Table 13). This finding contradicts the study of Clayman, et al., (2005), in which the female chaperones were verbally active and facilitated both the patient and the physician by showing a greater understanding than their male counterparts. This could be because the number of male chaperones in the current study is more than the number of female counterparts, whereas in Clayman, et al., (2005) there were more female chaperones than males. It could also be that male chaperones are more explicit than female chaperones in clarifying and expanding patients' responses than their female counterparts. It is possible that male chaperones had positive and informative experiences aligning with male doctors more than their

female counterparts. This might also be strongly related to the cultural norms regarding gender segregation in Saudi Arabia. Saudi women are not allowed to talk to strangers, especially men, which is regarded as a culturally objectionable situation if it happens. Moreover, it is possible that female chaperones find it difficult to align either with patients or doctors if there are three male doctors in the consultation room. There was strong evidence in my data where a female chaperone informed me that she could not explain her mother's symptoms because there were three male doctors in the room. These results are similar to those yielded by Nigeda, et al's (2003) study in which Saudi women find it problematic to communicate with male doctors because of the traditional cultural values of Saudi society in terms of interacting with males. Therefore, they prefer to interact with female physicians due to the Saudi organisation system of sex segregation in all public activities.

With the findings of gender variation and alignment norms in Chapter 6, and the points discussed above, we can conclude that conversation analysis does not only analyse the alignment norms which are linked to participants' understanding of these rules but also analyses when these norms are violated according to Saudi culture when the patient has not been given the right to be made aware of his or her illness. The following section presents the findings of the conversation analysis of the audio-recorded data regarding epistemic asymmetry of two exceptional cases from oncology clinics.

#### **8.2.4. Epistemic asymmetry in three-party medical interaction**

In Chapter Seven, I have examined a real-life problem, i.e. epistemic asymmetry based on observation of third-party medical interactions in Saudi Arabia. Two exceptional cases were chosen because they represent clear examples of epistemic asymmetry in medical interactions as they show epistemic fissures that breach the epistemic norms in social interaction. I have also investigated the various ways epistemic asymmetry interferes with the patient's primacy and autonomy. The findings show that the chaperone tends to speak for the patient even if the patient is mentally competent. The chaperone uses various epistemic markings in order to confirm the physician's history-taking questions by using the alignment token, 'yeah', full repeat, and assessment by providing evidence based on their (chaperones)

objective observations. The findings support previous conversation analysis research (Heritage, 2012a, 2012b; Sidnell, 2012; Stivers, 2005; Stivers, et. al., 2011), that participants taking part in social interaction can confirm or assess a situation based on their partial or complete access. In addition, our findings also support Opsahl's (2009) study, in using the discourse marker 'wallah' (i.e. I swear to God) to confirm and assess a certain situation. The discourse marker 'wallah' in Opsahl's (2009) study serves as the epistemic resource which gives importance to the utterance being assessed.

The findings also indicate that chaperones act both as an observer and as a witness for some aspects of the patient's health complaints which are related to physical and externally visible problems (such as vomiting) (see Extracts 7.2.5 and 7.3.3). This is in line with extant research (Lee & Kim, 2015; Mazer, et al., 2014) in which chaperones provided "observation as an outsider" (Mazer, et al., 2014; p. 39) regarding patients' visible complaints. In reporting patients' symptoms, it was noticed that patients in the current study were excluded from doctor-patient interaction because of the chaperones' referral to the patient as 'she' or 'her'. This finding is in line with previous studies (Coupland & Coupland, 2000; Hasselkus, 1992; Greene, et al., 1994; Mazer, et al., 2014; Tsai, 2007). For example, chaperones in Coupland & Coupland's study (2000), were mostly those who reported their observations with regards to patients' complaints by using the third-person reference (he/she), when talking about the patients, even if the patient was cognitively competent. In addition, this study found that patients reported their inner experiences by interrupting their chaperones to initiate a repair and fill the missing gaps (see Extracts 7.2.6 and 7.3.4). This finding is consistent with Tsai's (2007) study in that when chaperones lack direct access to patients' physical feelings the patients intervened to report their inner experiences. Chaperones in the current study resemble the findings of previous research (Hasselkus, 1992; Greene, et al., 1994; Mazer, et al., 2014) in which they acted as 'surrogate patients' or 'patient substitutes'. The findings of this research suggest that the chaperone has a negative impact on the patient's epistemic entitlement because the chaperone limits patient participation. Chaperones almost always answered the doctor's questions even if they were addressed to the patient. Our study is different from extant research (Clayman, et al., 2005; Mazer, et al., 2014; Tsai, 2007) in that the chaperone's dominating attitude in this study affects the patient's engagement in

decision-making as well as in epistemic primacy, whereas in other research (e.g. Clayman, et al., 2005) the chaperone's dominating attitude did not affect patients in making informed decisions. This could be because the patients taking part in previous research (e.g. Clayman, et al., 2005; Tsai, 2007) did not suffer from a chronic illness such as cancer. More importantly, it is possible that patients did not show any negative attitude regarding the chaperone's dominating role because they may have gone to their appointment seeing the chaperone as 'a patient's surrogate' (Aljubran, 2010). It has also been found that when chaperones reported their observations regarding patients' symptoms, the oncologists did not ask the patient either to confirm or disconfirm what their chaperones said. This finding is consistent with Lee & Kim's (2015) findings that physicians regarded chaperones' observations of patients' visible complaints as an authoritative description without requesting the patients' confirmation of what has been reported. This suggests that physicians should say to patients 'tell me what you think', or ask 'do you have something to add?'

Findings have also shown that although the female patient—in the current study—is considered as the owner of her illness, her chaperone has an asymmetrical position with regards to knowledge. That is to say, the chaperone displays an asymmetrical position of non-entitlement for not being the authoritative source of the knowledge. In an example of this, the chaperone lacks sufficient knowledge about her mother's health problem and inner feelings (see Extract 7.3.5) by using different resources such as the hedges: 'I don't know', 'it seems', delayed response, hesitation, and repetition. All these resources indicate an undesirable response. Although the doctor directed questions to the patient asking about her complaint, the chaperone was the available respondent for further discussion. Therefore, the chaperone places herself in a non-authoritative as well as asymmetrical position. The findings of this study are in line with Enfield's, (2011) and Sidnell's, (2012) works in that by claiming lack of epistemic access to a certain situation, the participant may need to use different resources to indicate lack of knowledge, such as hedges, 'it seems', hesitation, delayed response and repetition. The findings suggest that physicians should be aware that a patient's first-hand experience should not be delivered by the chaperone when the patient is cognitively competent and able to speak about his/her own body, illness and experience. Physicians should talk to the patients directly about their understanding

of their illness, their expectations about the diagnosis and treatment plan (protocol). In addition, patients need their chaperones' support during their illness. Patients have the epistemic right regarding the diagnosis of their illness. Therefore, the findings suggest that physicians and chaperones should work 'in sync' (Speice, et al., 2002, p. 102) with the patients, by clarifying the diagnosis of their illness, assisting with treatment plans and remaining in contact with healthcare providers. Working together 'in sync' would enhance the process of patient care and identify chaperones' needs.

The findings have also shown how cultural norms have an impact on doctor-patient interaction when discussing the diagnosis of cancer. The analysis suggests that there is a strong association between the chaperone's epistemic dominance, which becomes exacerbated, and the stress and anxiety of cancer diagnosis (Speice, et al., 2000). The analysis also indicates that the concealment of a patients' cancer diagnosis remains a major problem for oncologists and chaperones in Saudi Arabia. Findings from the data show that although the patient (Noura) was present during the oncologist-chaperone dyadic interaction, she was left isolated. Both oncologist and chaperone use various linguistic features to display shared knowledge about the patient's disease, such as repetition of the word 'the disease', the conjunction 'as well', the definite article, 'the', and the use of the common knowledge component 'you know' (see Extract 7.2.7). The finding of shared knowledge is consistent with Asmuß's (2011) study in that questions about epistemics have significance in displaying shared knowledge. For example, the use of 'you know' in the interaction is a device of shared knowledge. Moreover, the shared knowledge findings support the conclusions of previous research (Holland, et al., 1987). For example, Holland, et al., (1987) found that physicians from twenty countries reported that they frequently used various lexical items as substitutes for the word "cancer" (such as 'disease') for two purposes: (1) to refer to the patient's health condition, and (2) to decrease the impact of cancer disclosure.

It is worth noting that the issue of the oncologist-chaperone shared knowledge (of the patient's cancer diagnosis without the knowledge of the patient) is closely related to questions of morality. These are primarily focused on epistemic access and the patient's primacy and right to know the truth about her illness, which is regarded as one of the most basic human rights (Al-Amoudi, 2014).

In summary, the above-mentioned findings obtained from the quantitative and qualitative methods used are now collocated to gain a better understanding of the nature of three-party medical interaction in Saudi Arabia and what is gained from each data source, as shown in the following section.

### **8.3. Integration and Evaluation of Mixed Method Results**

As shown in Chapter 1, the motivation for this thesis emerged from the cultural tradition of the Saudi society where the Saudi female patient has to be accompanied by a chaperone when seeking treatment from a male physician. Therefore, the overall aim of the current research was to gain an in-depth understanding of the phenomenon of three-party consultations in Saudi Arabia by asking four research questions. These questions are: (1) What are the factors (if any) that affect patient satisfaction in three-party consultations? (2) What are the perceptions of female patients regarding their chaperones' roles during their medical visits? (3) How does alignment occur in three-party interactions? and, (4) How is epistemic asymmetry managed in triadic interactions?

A convergent mixed methods design was used to answer the research questions. A total of 117 female patients along with their chaperones — as a convenience sampling — were recruited (see Chapter 3). The data for this study included quantitative and qualitative data collected concurrently from twenty clinics in three hospitals in Jeddah, Saudi Arabia (two private and one governmental). Concerning the quantitative data, a post-visit questionnaire (i.e. patients' self-ratings about the medical visit when the third-party was included) was completed. In terms of qualitative data, four open-ended questions were used to ask about patients' experiences of having their chaperone present during the consultation. In addition, actual three-party medical consultations were observed and recorded. Regarding data analysis, statistical analysis (see Chapter 4) was conducted for the quantitative data whereas thematic analysis (see Chapter 5) and conversation analysis were conducted (see Chapters 6 and 7) for the qualitative data. On integrating the quantitative and qualitative data, the question that needs to be answered is: In what ways do quantitative and qualitative results converge and diverge? When comparing the mixed methods used in this study, congruent and

discrepant results have been found between the databases. Each will be discussed in turn.

In terms of congruent results, overall, when integrating results of different analyses with different data, the findings of this study indicate the importance of having a supportive chaperone during a female patient's medical appointment. Chaperones' supportive roles appear to influence female patients' symptoms, diagnosis or treatment plans in different ways. Chaperones in the current study have provided a useful contribution to doctor-patient interactions. In addition, they portray themselves and behave as responsible caregivers who are concerned with the patient's health, and who are keen to support the patient either by speaking on her behalf (see Chapters 4 and 5) or by providing more information about the symptoms of her illness (see Chapter 6). For example, in Chapter 6, the various types of alignment that emerged in three-party consultations in this study are co-operative and supportive in achieving the goal of the visit (i.e. enhancing mutual understanding and increasing the patient's adherence to the treatment plan). In addition, both the physician and the chaperone treat the patient as the individual, in the primary informant role, who has the primary right to respond when she is selected to be the next speaker.

However, three discrepant findings were discovered between the statistical and thematic analyses of the questionnaire data in addition to the conversation analysis of the audio-recorded data. First, the statistical analysis of the questionnaire data (see Chapter 4) indicated that patients with secondary and higher education were more satisfied with their chaperone involvement than patients with elementary and intermediate education. However, findings from the thematic analysis of patients' responses (Chapter 5) revealed that some female patients (10%) reported that they preferred their female chaperones to speak on their behalf because of their illiteracy. Some also wrote that they did not know how to interact with their physician. Although patients' education seemed to have a significant effect on their satisfaction with chaperone involvement, the degree of satisfaction differs according to their levels of education. While statistical and thematic analysis found that patients' levels of education affect their satisfaction with chaperone involvement, conversation analysis of the audio-recorded data showed no effect of education on patient satisfaction.



Second, findings from the thematic analysis (Chapter 5) of the open-ended questions data showed that a patient's age had an impact on patient satisfaction with her chaperone involvement. For example, some younger female patients (10%) wrote that they preferred their male chaperone to speak on their behalf especially when discussing intimate subjects, so they described themselves as dependent on their male chaperones. However, there was no indication of the impact of a patient's age on her satisfaction either in the quantitative (Chapter 4) or the qualitative (see Chapter 6) data.

Third, findings yielded by the conversation analysis (in Chapters 6 and 7) showed a discrepancy between what patients reported (see Chapters 4 and 5) about their chaperones' supportive roles and what their chaperones did in the consultation. For example, the thematic analysis of the open-ended questions found that both genders were equally likely to be active in speaking for the patient. However, the conversation analysis of observational data adds and clarifies to what patients reported about their chaperones speaking on their behalf. The conversation analysis has given a good picture of the chaperone's supportive role during medical visits in orienting towards patients as being the actual owners of their bodies and illness (see Chapter 6). Therefore, patients were given the chance to present their problem and report their medical history to their physicians. Chaperones, in working collaboratively with patients and physicians, support the patient and facilitate the physician's understanding. However, in only two exceptional cases (see Chapter 7) of actual medical interactions, the chaperone acts as a surrogate patient and restricts the patient's own knowledge of their illness. As a result, findings from the statistical and thematic analyses were thus incompatible with what was reported and what was really observed concerning the informational support provided by both chaperones.

Fourth, in terms of gender variation, the findings obtained from quantitative data (Chapter 4) showed no significant effect of chaperone gender on patient satisfaction with chaperone involvement. However, the thematic analysis of open-ended questions found that both male and female chaperones were equally likely to be active in speaking for the patient. However, by counting the frequency of alignment by consultation and the total number of instances across the data, the conversation analysis of the alignment formation in actual three-party consultations (see Chapter 6) found that male chaperones aligned with their sick relatives and physicians more than

female chaperones. Such discrepant results could be explained by the fact that the higher proportion of male chaperones who aligned with either patients or with physicians in actual medical consultations are higher in number (58) than their female counterparts (47).

The discrepant findings that were discovered between the quantitative and qualitative data, leads us to ask: What are the causes of these discrepant results? How can we resolve this problem? Which method is more applicable — the quantitative or the qualitative? Plus, to what extent can the findings of the current study be generalised for other hospitals and patients in Saudi Arabia or maybe for other cultures? The answers to these questions are discussed in turn.

The discrepancy in these findings may be a result of the following methodological limitations. First, the questionnaire was devised to be short (see Chapter 4) as recommended in previous patient satisfaction studies (Salisbury, et al., 2005; Thayaparan & Mahdi, 2013) for different reasons, one of which is that patients might be tired and they might not have time to fill in the questionnaire. In addition, the current study examined two variables: chaperone care and chaperone involvement. Although the statistical analysis of the questionnaire data in this research revealed some level of patient satisfaction with chaperone involvement, the development of new measures of chaperone care and chaperone involvement in a three-party medical visit is needed for future research in order to estimate accurately any effect of patient demographic characteristics or chaperone's care/involvement on patient satisfaction, and to lead to some correlation between the two methods. Moreover, transforming the themes that emerged from the qualitative data first into quantitative data by changing them to numeric information could be a possible resolution in order to reconcile the divergent findings (Crewell & Clark, 2011).

Second, the four open-ended questions might not have yielded sufficient information to fully understand the patients' perceptions regarding their chaperones' roles and gender variations. Other methods could have potentially yielded more detailed findings. In particular, a follow-up personal interview/semi-structured interview could have revealed interrelated categories of the chaperone's role that would better describe different types of support offered to the patients. From a practical

point of view, being aware of these limitations will help the researcher to improve the use of mixed methods in any upcoming research.

Third, the discrepant findings between quantitative and qualitative data regarding gender variation might be due to the unequal gender presentation; male chaperones were of a higher number (58) than their female counterparts (47). Therefore, to compare gender effect on patient satisfaction, future research should be based on a matched sampling procedure, ensuring equal gender representation and thus more objective results.

Fourth, the discrepant results regarding the effect of patients' education on patient satisfaction with chaperone involvement in the quantitative (Chapter 4) and qualitative (Chapter 5 and 6) data are due to the analysis methods. For example, in the audio-recorded data, no reference to education was found. The rationale behind investigating the impact of education in naturally occurring data goes beyond the limits of conversation analysis.

In evaluating the quality of the research, here I address the questions stated above, i.e. Which method is more applicable — the quantitative or the qualitative? Plus, to what extent can the findings of the current study be generalised for other hospitals and patients in Saudi Arabia or even in other cultures? With regards to which method is applicable, in my view both methods complement each other if the aim is to provide a comprehensive understanding of a research problem, which neither quantitative nor qualitative approaches do if they are used in isolation. It has been found that each method offsets the weaknesses of the other as well as clarifies the unexpected or contradictive findings obtained from the other methods. For example, findings from the statistical and thematic analyses revealed that illiterate patients (Chapter 5) and those with a secondary and higher level of education (Chapter 4) were satisfied with their chaperone involvement (i.e. speaking on their behalf). Moreover, the thematic analysis revealed that both male and female chaperones were equally likely to speak for the patient. The conversation analysis of the observational and audio-recorded data (the answers to the third and fourth research questions) added specific and detailed meaning to the findings obtained from the statistical and thematic analyses. In speaking on behalf of the patients, the conversation analysis of the audio-

recorded data was not congruent or compatible with what patients reported regarding their chaperones speaking for them. Rather, the conversation analysis clarifies the findings gained from the statistical and thematic analyses by showing that the chaperones acting as a surrogate patient were found in two exceptional cases only (Chapter 7). The conversation analysis showed how epistemic norms are violated according to the Saudi culture when the patient is not given the right to know the reality of her illness. Apart from this, chaperones were supportive to both patients and physicians in medical interactions.

As far as generalising the findings of the current research is concerned, it is important to note here the results of this study cannot be generalised for a wider population due to the following methodological limitations. First, this study was conducted in Saudi Arabia, where the presence of a male chaperone with a Saudi female patient is necessary for cultural as well as religious reasons when seeking treatment from a male physician. The findings reported here might not be applicable to other cultures where such restrictions do not apply.

Second, this study was conducted using a convenience sample of male physicians, Saudi female patients, and their chaperones, recruited from one governmental and two private hospitals in Jeddah. Therefore, the findings of the study are limited to this selected population and to the three hospitals in Jeddah in Saudi Arabia. Consequently, the potential for generalising the findings is limited, as the sample may not represent the greater population of male doctors, female patients, or their chaperones, in Saudi Arabia.

Third, the majority of patients who participated in the study had been diagnosed with cancer. Other patients from different clinics with different illnesses might have provided different responses regarding their chaperones' roles during their medical visits, and thus have yielded alternative findings based on their needs.

Fourth, information might be lost by not considering patients with group chaperones (i.e. more than one male or female, or a combination of both). Patients are in a position to judge the quality of care being provided by their group chaperones in medical consultations. Investigating patients' attitudes regarding their group chaperones could contribute to understanding group interactions and whether or not

male or female chaperones divide their roles<sup>89</sup> among themselves during their sick relative's appointment. Such an important source of data might yield new and interesting themes about the care provided by group chaperones for their sick relatives; an area which has not been investigated before.

Fifth, filling in the questionnaire<sup>90</sup> for the illiterate patients after asking the questions orally might have affected the results, as it is possible that some patients felt uncomfortable with the researcher completing the questionnaire on their behalf. In addition, they may have felt that the questionnaire was an intrusion into their privacy, which could have affected their perceptions regarding rating the medical visit, and the presence of their chaperone.

Sixth, this study is limited to certain patterns of alignment found in three-party medical interactions in Saudi Arabia. Care must be taken in extrapolating the results to other interactional circumstances.

Seventh, while the two exceptional cases (discussed in Chapter 7) have shown only a partial picture of epistemic asymmetry in the doctor-patient-chaperone encounter, this could still provide a starting point for more comprehensive studies since there is a lack of conversation analysis research on such a critical issue in Saudi Arabia, which represents a preliminary step towards understanding three-party interactions in this country.

In spite of these limitations, the results obtained from the mixed method design in this thesis contribute to the three-party literature and have clinical implications on three-party interactions in Saudi Arabia as shown below.

#### **8.4. Contribution and Implications of the Thesis**

The current study contributes to three important areas, namely, the literature of three-party interactions, three-party interactions in Saudi Arabia, and clinical practices in Saudi Arabia. Each is discussed in turn.

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<sup>89</sup> A chemotherapy clinic was observed where a female patient was accompanied by group chaperones (i.e. her son and daughter). The supportive roles between the male and female chaperones were divided, in which the male chaperone interacted with the male physician whereas the female chaperone provided physical assistance to the patient during the medical examination.

<sup>90</sup> A statistical test was done to check if there was any effect between completing the questionnaire alone or assisted on the patient satisfaction questionnaire. The results indicated no effect.

#### **8.4.1. Implication for the study of three-party interactions**

The current study makes a number of contributions to three-party consultations research. First, this thesis addresses an existing gap in the qualitative research with regard to the patients' perceptions regarding their chaperones' roles in medical consultations. Therefore, this study expands the literature on the chaperones' roles and gender variation in the types of support offered to the patients by empirically exploring the patients' experiences, which has not been investigated in prior research. In addition, the current study adds to the literature of patient perceptions—regarding their chaperones in the medical consultation—by providing the reasons behind the patient's choice of the most important support they need from their chaperones.

Second, this study expands the extant literature on three-party roles and alignment formation during a medical visit by empirically observing medical interaction and alignment types that might be developed during the interaction. The results reported here augment the limited literature on alignment in adult three-party interactions in medical encounters. This subject has rarely been studied in depth, especially from the perspective of conversation analysis.

Third, the current research addresses a methodological gap in investigating epistemic asymmetry from the conversation analysis perspective, as epistemic asymmetry is a new field in this research. This study adds to a small amount of literature which currently exists on epistemic asymmetry in third-party medical consultations, which has not been studied in depth. Therefore, the conversation analysis framework has theoretical implications in the study of epistemic asymmetry. This means that the participants in my study (as shown in Chapter 7) use epistemic resources which have been observed in previous western studies of conversation analysis. Therefore, this study shows the cross-cultural relevance of some of the epistemic resources investigated in conversation analysis literature. Another methodological contribution is that the conversation analysis framework can effectively be employed to analyse data from other cultures (Wong & David, 2000).

#### **8.4.2. Implication for the study of three-party interactions in Saudi Arabia**

This study also has implications for the study of three-party interactions in Saudi Arabia in different ways. First, thematic analysis of the open-ended questionnaire data adds new knowledge to the existing literature regarding Saudi Arabian culture, in terms of the type of support the chaperone offers to their sick relatives. In particular, the findings revealed some important gender differences in terms of the care chaperones provide to Saudi female patients which have not been investigated in prior research.

Second, this research contributes to the existing conversation analysis knowledge by adding further detail of how alignment and affiliation go hand in hand in Saudi three-party medical interactions. In addition, in my view, both types of alignment make important contributions towards understanding chaperones' social roles to support their sick relatives in Saudi Arabia. Furthermore, it explores the interactional features of alignment in medical clinics and elucidates how these features may provide insights into the chaperones' facilitative behaviour towards both the doctor and the patient.

Third, the analysis of the exceptional cases in Chapter Seven suggests that a conversation analysis framework for a third-party medical encounter can be usefully employed to investigate the features of epistemic dysfunction of institutional medical encounters in other cultures, i.e. the patient remains blind to her disease. Therefore, a conversation analytic approach to epistemic asymmetry provides a new perspective on how the social norms in the domain of knowledge (i.e. primacy, access, and responsibility) are violated according to the Saudi culture. The violation of knowledge norms is managed and maintained between the oncologist and the chaperone. Also, the morality of knowledge is violated; there is no equal right for patients to speak for themselves, and the impediment of patient participation is associated with the chaperone's protective behaviour.

### 8.4.3. Implications for clinical practices in Saudi Arabia<sup>91</sup>

This study also has clinical implications for the study of three-party interactions in Saudi Arabia as follows. First, female patients emphasised female chaperones' continuing role in providing emotional support physically and verbally. This shows that chaperones (and, of course, physicians as well) are expected to fulfil patients' needs by reducing their psychological stress, minimising their worries, offering hope (particularly, to cancer patients), promoting an optimistic outlook on life, and giving them encouragement. Being able to meet these needs might have a great effect on the patients' ability to cope with cancer. Moreover, based on patients' responses, male chaperones showed less emotional support than their female counterparts. Therefore, male chaperones should be encouraged to be more physically and verbally supportive of the female patients.

Second, findings from the statistical and thematic analyses (see Chapters 4 and 5) revealed that illiterate female patients and those with secondary and higher level education prefer their chaperones to speak on their behalf. Therefore, patients should be encouraged to talk to their physicians about their illness because it is their illness, their bodies, and their experience. It is recommended that a health education programme should be developed by the Ministry of Health, or by local hospitals, where counselling and educational sessions are offered to Saudi female patients, in order to eliminate their misconceptions about the importance of communicating their illness directly to their physicians, regardless of their levels of education, type of illness and age, and without requiring anybody to speak on their behalf. These sessions should be supported by appropriate web-based resources and leaflets, which address the issues of a patient's right to speak for herself.

Third, the findings derived directly from the actual audio-recorded three-party medical consultations (see Chapter 6) revealed accurate and obvious practical information. The conversation analysis suggests that recognising the important function of chaperone-patient (and patient-chaperone) and chaperone-doctor (and chaperone-patient) alignments are considered an important turning point in enhancing the patient's quality of care. Therefore, the chaperone should be encouraged to align

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<sup>91</sup> For the dissemination of the findings of the current research, after the examination of this thesis I am planning to send a more detailed report on the main research findings to the three hospitals, the patients and their chaperones who participated in this study.



with the patient in order to clarify and add significant information about the patient's illness and at the same time facilitate their physician's understanding of the patient's health problems. In this role, the chaperone would accomplish the goals of the visit, which can have significant effects on the process and outcome of the patient's care. In terms of chaperone-physician alignment, the study suggests that the discussion of the treatment plan in the presence of the patient's chaperone leads to the patient's and chaperone's mutual understanding and increases adherence to the treatment plan.

Findings from conversation analysis of two exceptional cases (see Chapter 7) raise ethical concerns about patient autonomy as well as the physician's roles and responsibilities regarding maintaining and managing patient's epistemic entitlement. I have shown in Chapters Two and Seven that the social structure in Saudi Arabia is based on strong family ties instead of on personal autonomy (Aljubran, 2010; Khalil, 2013). I have also discussed that the disclosure of cancer diagnosis in Saudi Arabia is still correlated with social stigma and a misconception of incurability (Khalil, 2013). I have also shown that cancer disclosure remains a major problem for physicians and chaperones in Saudi Arabia. Therefore, policies of truth disclosure and respecting the patient's epistemic primacy in Saudi Arabia, a very conservative country, have not yet changed. To handle the difficulty of disclosing cancer diagnosis or even therapy failure, the following clinical implications are provided for the Ministry of Health, policy makers, physicians and chaperones.

The Ministry of Health should develop a code and legislation concerning patient autonomy. Therefore, patients should be informed first of their diagnosis and physicians should be frank with them from the initial visit (Okamura, et al., 1998). There is strong evidence that patients cope better with their serious illness only if they have been told about it (Manuel, et al., 1987). However, patients with an incurable illness should be made aware of the treatment options in order to make a sensible decision about end-of-life care. Physicians should guide chaperones to be supportive rather than dominant and take an asymmetric role to respect patient autonomy.

For policy makers, education programmes of how to disclose bad news to patients and their families as well as how to deal with a chaperone's dysfunctional

dynamics should be included in the Saudi medical schools' curriculum and should be part of their postgraduate training (Aljubran, 2010; Karim, et al., 2015).

There should be a training session and open discussion for both physicians and chaperones regarding the concept of the patient's epistemic primacy and its relation to the disclosure of cancer for various purposes: disclosure of patient illness is strongly supported by the Islamic perspective of respect for the patient as an individual who has the right to know about the disease he/she has and make decisions regarding his/her therapeutic procedures. In addition, disclosure is also supported by the patients' needs as stated in previous studies, the majority of patients need a full disclosure of their illness, treatment plan, and even more importantly failure of therapy. All these ideas help to build a doctor-patient trustful relationship, share decision-making and plan the end of life, (e.g. writing a will) (Aljubran, 2010). In addition, there are strategies that the oncologist should follow to reduce epistemic asymmetry in oncology clinics (Spiece, et al, 2000): these are (a) physicians should interact with patients and their chaperones to provide them with accurate information about patient diagnostic problems, (b) physicians should openly state to the chaperone that the patient has the epistemic priority to have full information about her illness, (c) the patient should be informed about the treatment plan or even treatment failure, and (d) physicians should ask the chaperones what their loved ones would feel if they knew that their physicians and chaperones had concealed their illness.

However, lack of candour and trust in disclosing patient diagnosis means a physician-patient mistrustful relationship (Drane & Reich, 2002). A physician's dishonesty results in a tragic end in medicine within the medical field, therefore, the patient's autonomy is hurt, they are deceived<sup>92</sup>, and physicians are harmed, in one word, trustworthy medicine as a whole loses its authority (Drane & Reich, 2002). In this case, there is no difference between lying in doctor-patient interaction and lying in a daily life situation. If we have lost trust in a friend because of a lie in our social

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<sup>92</sup> A surgical oncology clinic was observed, where the female patient was deceived by her female oncologist and her male chaperone. The patient had been informed that she had a benign tumour in her cervix although in reality she had reached fourth stage cancer in which the tumour had spread throughout her body. The surgeon had to inform the patient of the reality. The patient was shocked, and was in tears. The patient informed me that she was deceived by her oncologist and her husband.

interaction, what if this happens in a medical institution, where the physician collaborates with a chaperone to give untruthful information to the patient or conceal the loved ones' illness? Can the patient re-build that trust again? I do not think so. Therefore, physicians should not surrender to chaperones' wishes to conceal information from patients in order to maintain trust and high quality of care.

In summary, the findings of this research may be used as a springboard from which upcoming research is developed. Researchers may focus their attention on one aspect of triadic interactions or address different aspects of three-party consultations as summarised in the following section.

### **8.5. Recommendations for future research**

To my knowledge, this is the first study of three-party interactions in medical settings involving adult Saudi female patients, over a wide range of ages, which has been conducted in Jeddah, Saudi Arabia. The current research represents a preliminary step toward understanding three-party interactions in Saudi Arabia. The findings of this study have provided answers to the research questions that have arisen from the cultural tradition of Saudi society where a Saudi female patient has to be accompanied by a chaperone when seeking treatment from a male doctor. The study findings, limitations and implications have also offered some important avenues for further research in the area of three-party interactions in relation to gender variation, some of which are discussed below.

First, the current study examined two variables, chaperone care and chaperone involvement. Although the statistical analysis of the questionnaire data in this research revealed some level of patient satisfaction with chaperone involvement, the development of new and reliable measures of chaperone care and chaperone involvement in a three-party medical visit is needed for future research to estimate accurately any effect of patient demographic characteristics or chaperone's care/involvement on patient satisfaction. In addition, to compare gender effects on patient satisfaction, future research should be based on a matched sampling procedure, ensuring equal gender representation and thus more objective results.

Second, it would be valuable to conduct a close analysis of outliers (i.e. the five neglected negative responses - in Chapter 5 - yielded by female patients regarding their chaperones' involvement during their medical appointments) in order to get a full picture of triadic interaction on the one hand and to investigate any link between patients' negative attitudes and their dissatisfaction with third-party medical consultation on the other.

Third, it would be beneficial to explore female patients' and their chaperones' views regarding the role of the chaperone in the medical encounter in order to examine the level of agreement between the two groups. This understanding might have great effects on patients' needs and their satisfaction with the medical visit.

Fourth, the current study revealed that there was a discrepancy between what patients reported regarding their chaperone's advocacy role and what was actually observed in three-party interactions. Therefore, more qualitative studies are recommended to explore the perceptions of female patients regarding their chaperones' advocacy roles and what is actually observed during a medical visit, in order to examine the level of agreement between what is being reported and observed in a real-life context.

Fifth, the alignment patterns that are investigated in this thesis are limited to three-party medical consultations in Saudi Arabia. Hence, further studies are needed to investigate whether the same patterns would be found in other contexts or whether they are particular to Saudi medical consultations.

Sixth, the findings of the exceptional cases in Chapter Seven suggest the distinctive need for conducting more case studies (a large collection of cases in order to observe the variation in the phenomenon of epistemic asymmetry in a reliable way) to understand the practices of epistemic asymmetry of cancer non-disclosure, particularly, with terminally ill patients, from a conversation analysis perspective.

To conclude, this thesis has added new knowledge to the area of three-party consultations in a different culture. When I started this research I did not realise how much I would learn from the mixed methods research. I hope that the outcome of this research can make a practical difference for policy makers, physicians and chaperones in order to assist them with delivering more effective care and improving the quality of care, particularly, for cancer patients in Saudi Arabia.

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<sup>94</sup> No issue number available.



## Appendix 1: Ethical approval from the private hospital (H1)



المركز الطبي الدولي  
International Medical Center

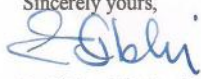
To : Maha Al-Ayyash  
Department of Linguistics and English Language  
The Edinburgh University


Subject: Approval of research proposal entitled "The participatory dynamics of doctor-patient-caregiver triadic medical consultations in Saudi Arabia"

Date : 4 October 2010

Kindly be informed that your proposal has been approved. Please forward us with copies of all consent forms for our records for safekeeping. In the meantime, I will send an email to all Chairmen of relevant department to extend their support to you during the execution of your project. So, it is your responsibility to communicate with the concerned Department Chairman and staff to define your needs and get their support.


Good luck!

Sincerely yours,  
  
Prof. Ezzeldin Ibrahim  
Senior Consultant, Oncologist  
Director, Oncology Center of Excellence  
Executive Director, Research Center



Dr. Ezzeldin Ibrahim  
Senior  
Consultant, Oncology  
البرو # 67

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## Appendix 2: Ethical approval from the private hospital (H2)



مستشفى الدكتور سليمان فقيه  
Dr. Soliman Fakeeh Hospital



DR. SOLIMAN FAKEEH HOSPITAL  
Research and Ethics Committee  
Research Approval Form

Title of Project: **The participatory dynamics of doctor-patient-caregiver triadic medical consultation in Saudi Arabia**

Application No.: 09/2010 Approval Number: 09/REC/2010

Chief Investigator/s: **Maha Al-Ayyash**

Address: School of Philosophy, Psychology and Language Science, University of Edinburgh [M.Al-Ayyash@sms.ed.ac.uk](mailto:M.Al-Ayyash@sms.ed.ac.uk)

The Research and Ethics Committee at DSFH has decided to assign the above-mentioned research protocol the following approval category:

Category 1: Approved.

*This is a Research and Ethics Committee approval given retrospectively to the above mentioned study.*

*It has been granted by Dr. Hatem Eleishi, the Chairman, without the need for a committee meeting as the study's methodology does not subject patients to more than the minimal adverse events expected.*

*The organization & operating procedure of the Research and Ethics Committee at Dr Soliman Fakeeh Hospital are based on the Good Clinical Practice (GCP) Guidelines;*

*The REC must receive an annual report on the course of the study and must receive a final report upon completion of the study.*

*Strict compliance with the policy on "Research Approval by the Research and Ethics Committee" that is attached to this approval is mandatory. In particular, obtaining a written consent from participating patients and subjects in this particular study is MANDATORY*

*The name of the Research Center (Dr. Soliman Fakeeh Hospital) must be mentioned in any publications arising from the approved work unless it is a multicenter trial in which none of the participating centers' names will mentioned.*

Category 2: Some concern(s) must be addressed before approval is given.

Category 3: Decision is deferred pending receipt of supplementary information or documentation.

Category 4: Not approved. The reasons will be provided.

Chairman of REC: Dr. Hatem Eleishi Date: October 2<sup>nd</sup>, 2010

Director General: Dr. Mazen Fakeeh Date: October 3<sup>rd</sup>, 2010

## Appendix 3: Ethical approval from the governmental hospital (H3)

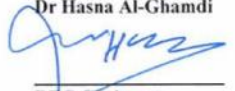


To: Ms Maha Abdelrahman Al-Ayyash  
Subject: Protocol: RU-0082  
Protocol title: Three-Party Consultations in Saudi Arabia: Structure, Gender, and Patient satisfaction  
Date: 04 Dec 2011

This is in reference to your subject proposal which has been reviewed by Independent Ethics Committee Chairman. You have been granted permission to conduct your study and your research proposal is approved for THREE MONTHS commencing from the above date under the following conditions

#### Terms of approval

1. Approval includes the following documents which were reviewed by the IEC members:
  - Study protocol
  - A questionnaire to filled by participants
  - A Consent form in English and in Arabic
2. Amendments to the approved project: changes to any aspect of project require the submission of a request for amendment to King Abdullah Medical City Oncology Center-Research unit (KAMCOC-RU), Jeddah and must not begin without an approval from KAMCOC-RU Substantial variations may require a new application.
3. All measures should be taken to protect patient confidentiality. All identifiable information will be protected from misuse or disclosure.
4. Notification about patient recruitment: a list of included patients identified by full name and medical record number (MRN) with the corresponding unique study number must be forwarded to the Research Unit after each visit to the oncology center.
5. Please provide KAMCOC-RU with an End of Study Report after finishing your field work at the institution.
6. A copy of each consent form should be brought to the research unit at the end of each working visit.
7. Future correspondence: please quote the project number and project title above in any further correspondence
8. KAMCOC-RU acknowledges the originality of your research proposal and ensures treating the proposal with the strictest confidentiality.

Dr Hasna Al-Ghamdi  
  
\_\_\_\_\_  
REC Chairman

### Appendix 4:

### Calendar of visits to the three hospitals in Jeddah, Saudi Arabia

November 2011

Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
			1	2	3 <sup>95</sup>	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21 H1 <sup>96</sup> 17:00-18:00 p.m.	22 H2 <sup>97</sup> 9:00 a.m.-13:00 p.m.	23 H2 <sup>98</sup> (9:00 a.m.- 13:00 p.m.) H1 <sup>99</sup> 14:00-17:00 p.m.	24 H1 <sup>5</sup> 9:00 a.m.- 13:00 p.m.	25

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<sup>95</sup> Although Thursday and Friday were weekends, some clinics in the two private hospitals were running.

<sup>96</sup> Meeting a Clinical Research Co-ordinator to renew the approval form in H1.

<sup>97</sup> Meeting the Executive Director of Medical Affairs in H2.

<sup>98</sup> Meeting the Chairman of Ethics and Research Committees and meeting the Head of the Oncology Department and the Oncology Surgeon.

<sup>99</sup> Meeting the Oncology Secretary about the name of the Saudi female patients attending the consultation, and meeting the Head of Orthopaedic Surgery. Meeting the Director of the Outpatient Clinic and asking for a list of patients' outpatient appointments in the orthopaedic and oncology clinics.

<b>26</b>	<b>27</b> <b>H2<sup>100</sup></b> <b>9:00 a.m.-13:00</b> <b>p.m.</b>	<b>28</b> <b>H2<sup>101</sup></b> <b>9:00 a.m.-13:00 p.m.</b> <b>H1<sup>103</sup></b> <b>14:00-17:00 p.m.</b>	<b>29</b> <b>H1<sup>102</sup></b> <b>9:00 a.m.-17:00 p.m.</b>	<b>30</b> <b>H1</b> <b>Starting data</b> <b>collection</b> <b>9:00 a.m.-13:00</b> <b>p.m.</b> <b>17:00-21:00 p.m.</b> <b>Piloting the</b> <b>questionnaire</b>		
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1

<sup>100</sup> Attending the ethics committee meeting.

<sup>101</sup> Meeting the Head of the Orthopaedic Surgery in H2.

<sup>102</sup> Meeting the Head of Surgery and meeting five surgeons as well as asking permission to attend their consultations.

<sup>103</sup> Meeting the Chemotherapy Oncologist in H1.

## December 2011

Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
					1	2
3 H3 <sup>104</sup>	4 H2 <sup>105</sup> 9:00 a.m.-21:00 p.m. Piloting the questionnaire No Saudi patient was found (collected 2 only)	5 H1 Data collection Piloting the questionnaire	6 H2 9:00 a.m.-13:00 p.m. No data found	7 H3 9:00 a.m.-13:00 p.m. Piloting the questionnaire	8	9
			H1 Data collection Piloting the questionnaire	H1 <b>17:00-21:00</b> <b>p.m.</b> No Saudi patient with her chaperone was found		

<sup>104</sup> Meeting the Head of the Oncology Centre to submit my application manually to the research centre.

<sup>105</sup> Although I spent the whole day in the hospital, I recorded two consultations.

Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
10 H3 9:00 a.m.-13:00 p.m. Data collection	11 H3 Data collection 8:00 a.m.-13:00 p.m. 13:00-17:00 p.m.	12 H3 Data collection 8:00 a.m.-13:00 p.m.	13 H3 Data collection 8:00 a.m.-13:00 p.m.	14 H3 Data collection 8:00 a.m.-13:00 p.m.	15	16
H1 17:00-21:00 p.m. Data collection (2)	H1 17:00-21:00 p.m.		H1 17:00-21:00 p.m.			
17 H3 Data collection 8:00 a.m.-13:00 p.m.	18 H3 Data collection 8:00 a.m.-13:00 p.m.	19 H3 Data collection 8:00 a.m.-13:00 p.m.	20 H3 Data collection 8:00 a.m.-13:00 p.m.	21 H3 Data collection 8:00 a.m.-13:00 p.m.	22	23

24 H3 Data collection 8:00 a.m.-13:00 p.m.	25 H3 Data collection 8:00 a.m.-13:00 p.m.	26 H3 No cases collected in the morning 13:00-17:00 p.m.	27	28	29	30
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**January 2012**

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<b>Saturday</b>	<b>Sunday</b>	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
30	1 9. a.m.-13:00 p.m. 13:00-17:00 p.m.	2 9. a.m.-13:00 p.m.	3 9. a.m.-13:00 p.m.	4 9. a.m.-13:00 p.m.	5	6
7 9. a.m.-13:00 p.m. 13:00-17:00 p.m.	8 9. a.m.-13:00 p.m.	9 9. a.m.-13:00 p.m. 13:00-17:00 p.m.	10	11 9. a.m.-13:00 p.m. 13:00-17:00 p.m.	12	13
14 9. a.m.-13:00 p.m.	15 9. a.m.-13:00 p.m. 13:00-17:00 p.m.	16	17	18 9. a.m.-13:00 p.m.	19	20

21 9. a.m.-13:00 p.m.	22 9. a.m.-13:00 p.m. 13:00-17:00 p.m.	23	24	25 9. a.m.-13:00 p.m.	26	27
28 9. a.m.-13:00 p.m.	29 9. a.m.-13:00 p.m.	30 9. a.m.-13:00 p.m.	31			

## Appendix 5: Outpatient Appointment List

**Page:**

Hospital's name

Tel:

Fax:

### Outpatient Appointment List

**Date:** \_\_\_\_\_

**Clinic:** \_\_\_\_\_

**Doctor name:** \_\_\_\_\_

Serial	File No.	Patient Identity No.	Gender	Patient Name	Age	Nationality	Responsible Nurse	Category <sup>106</sup>	File Location

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**Name<sup>107</sup>:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<sup>106</sup> There are different patient categories which benefit from receiving treatment from the oncology centre. Each patient has a specific symbol that indicates his/her category. Some of these are: F means free of charge, C means charged or paid by him/her.

<sup>107</sup> Name, signature and date are included here in order for the nurse who is responsible for each clinic to calculate the number of patients' files and the number of patients who were attending the clinic that day. After calculation, the nurse writes her name, signs, and also includes the date to revise the number and then hands it to the head nurse.

## Appendix 6: Observation sheet

Name of the hospital: \_\_\_\_\_

Date: \_\_\_\_\_

Clinic: \_\_\_\_\_

Doctor: \_\_\_\_\_

Time spent: \_\_\_\_\_

Patient's name: \_\_\_\_\_

Chaperone's name: \_\_\_\_\_

Relation to the patient: \_\_\_\_\_

Your city (Jeddah or coming from outside): \_\_\_\_\_

Reason for the visit: \_\_\_\_\_

\_\_\_\_\_:

\_\_\_\_\_:

\_\_\_\_\_ التاريخ:

\_\_\_\_\_ العيادة:

\_\_\_\_\_ الطبيب:

\_\_\_\_\_:

\_\_\_\_\_ اسم المريض:

\_\_\_\_\_:

\_\_\_\_\_ صلة قرابة المرافق للمريض:

\_\_\_\_\_ المدينة (جدة او خارج جدة):

\_\_\_\_\_ أسباب الزيارة:

## Appendix 7: Consent form for patients and their chaperones



اسمي مها العياش, طالبة دكتوراة في السنة الثالثة بجامعة ادنبرة بقسم اللغويات و اللغة الانجليزية في اسكتلندا,  
: " العيادات الثلاثية تكوينها و جنس المرافق و مدى رضى المريض عنها  
المملكة العربية لسعودية." الهدف من هذا البحث هو دراسة الدور الذي يقوم به مرافق المريضة  
و تأثير جنس المرافق على رضى المريضة.

تم تمويل هذه الدراسة بدعم من جامعة الملك عبدالعزيز بجدة و تمت الموافقة عليها من قبل لجنة البحوث  
اللغويات و اللغة الانجليزية بجامعة ادنبرة ورئيس لنة اخلاقيات البحوث الطبية في مدينة الملك عبدالله: مركز

ولذلك فانا التمس مشاركتكم في هذه الدراسة الهامة بالسماح لي لحضور و تسجيل الحوار الطبي. سوف يطلب  
ايضا اكمال استبيان قصير بعد الانتهاء من العيادة. ويتطلب منك ايضا تعبئة نموذج بخصوص التفاصيل  
السريية الخاصة بك.

اذا قررت المشاركة في هذه الدراسة ، فسوف يطلب منك أن تسمح لي بتسجيل الحوار الطبي. سيتم التعامل مع  
التسجيلات الصوتية ، وخاصة الحوار الطبي ، بسرية تامة. وسوف يتم تغيير اسمك في النصوص. وسيتم استخدام  
البيانات التي تم جمعها لأغراض بحثية فقط ، للباحث والملتحنين فقط الحق في الاطلاع على التسجيلات  
الصوتية. وسيتم إتلاف هذه التسجيلات بعد مناقشة أطروحة الدكتوراة بنجاح بأذن الله . يرجى التنويه بأن قر  
في المشاركة لن يؤثر على حقوقك بأي شكل من الأشكال ، و لن يؤثر على الخدمة العلاجية التي تتلقاها. وانوه  
أيضا أن بإمكانك الانسحاب من الدراسة في أي وقت بدون الحاق اي عواقب سلبية بك.

هذ الدراسة جاهزة في سبتمبر هذ يرجى تزويدي

إذا كان لديك أي أسئلة ، فلا تترددوا في الاتصال بي على البريد الإلكتروني ( [m.al-ayyash@sms.ed.ac.uk](mailto:m.al-ayyash@sms.ed.ac.uk) )  
بإمكانكم ايضا الاتصال بالبروفسور: عز الدين ابراهيم ، المدير التنفيذي لمركز الابحاث بالمركز الطبي الدولي  
(IMC) ومدير المركز المتميز للأورام على البريد الإلكتروني [ezzibrahim@imc.med.sa](mailto:ezzibrahim@imc.med.sa)

( +966 (02) 6509000 ) (أو الهاتف النقال 966 505 82 5953 +)

سوف يؤخذ توقيعك بمثابة اثبات على أنك قد قرأت وفهمت المعلومات الواردة أعلاه ، وأنك توافق على المشاركة  
في هذه الدراسة.

اسم المريض : \_\_\_\_\_ التوقيع : \_\_\_\_\_  
اسم مرافق المريض: \_\_\_\_\_ التوقيع : \_\_\_\_\_  
ايميل: \_\_\_\_\_ التاريخ : \_\_\_\_\_

## Appendix 7a: Consent form for patients and their chaperones (the Arabic version)



اسمي مها العياش, طالبة دكتوراة في السنة الثالثة بجامعة ادنبرة بقسم اللغويات و اللغة الانجليزية في اسكتلندا, المملكة المتحدة.  
:" العيادات الثلاثية تكوينها و جنس المرافق و مدى رضى المريض عنها في المملكة العربية لسعودية." الهدف من هذا البحث هو دراسة الدور الذي يقوم به مرافق المريضة و تأثير جنس المرافق على رضى المريضة.

تم تمويل هذه الدراسة بدعم من جامعة الملك عبدالعزيز بجدة و تمت الموافقة عليها من قبل لجنة البحوث بقسم اللغويات و اللغة الانجليزية بجامعة ادنبرة و رئيس لنة اخلاقيات البحوث الطبية في مدينة الملك عبدالله:

ولذلك فانا التمس مشاركتكم في هذه الدراسة الهامة بالسماح لي لحضور و تسجيل الحوار الطبي. سوف يطلب منك ايضا اكمال استبيان قصير بعد الانتهاء من العيادة. و يتطلب منك ايضا تعبئة نموذج بخصوص التفاصيل السريرية الخاصة بك.

المشاركة في هذه الدراسة ، فسوف يطلب منك أن تسمح لي بتسجيل الحوار الطبي. سيتم التعامل مع التسجيلات الصوتية ، و خاصة الحوار الطبي ، بسرية تامة. و سوف يتم تغيير اسمك في النصوص. و سيتم استخدام البيانات التي تم جمعها لأغراض بحثية فقط ، للباحث و الممتحنين فقط الحق في الاطلاع على التسجيلات الصوتية. و سيتم إتلاف هذه التسجيلات بعد مناقشة أطروحة الدكتوراة بنجاح بأذن الله . يرجى التنويه بأن قرارك في المشاركة لن يؤثر على حقوقك بأي شكل من الأشكال ، و لن يؤثر على الخدمة العلاجية التي تتلقاها. و انوه أيضا أن بإمكانك الانسحاب من الدراسة في أي وقت بدون الحاق اي عواقب سلبية بك.

هذه الدراسة جاهزة في سبتمبر هذ يرجى تزويدي بمعلومات خاصة بك لترسل

إذا كان لديك أي أسئلة ، فلا تترددوا في الاتصال بي على البريد الإلكتروني ( [m.al-ayyash@sms.ed.ac.uk](mailto:m.al-ayyash@sms.ed.ac.uk) )  
بإمكانكم ايضا الاتصال بالبروفسور: عز الدين ابراهيم ، المدير التنفيذي لمركز الابحاث بالمركز الطبي الدولي (IMC) ومدير المركز المتميز للأورام على البريد الإلكتروني [ezzibrahim@imc.med.sa](mailto:ezzibrahim@imc.med.sa) ( أو الهاتف النقال +966 505 82 5953 )

سوف يؤخذ توقيعك بمثابة إثبات على أنك قد قرأت وفهمت المعلومات الواردة أعلاه ، وأنك توافق على المشاركة في هذه الدراسة.

اسم المريض : \_\_\_\_\_ التوقيع : \_\_\_\_\_  
اسم مرافق المريض: \_\_\_\_\_ التوقيع : \_\_\_\_\_  
ايميل: \_\_\_\_\_ التاريخ : \_\_\_\_\_

## Appendix 8: Calendar of medical room observation from November 2011 –January 2012



= Audio recording in hospital 1



= Audio recording in hospital 2



= Audio recording in hospital 3




= Weekends















= Days of conducting audio-recordings

**November 2011**

<b>Saturday</b>	<b>Sunday</b>	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
			<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>
<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>
<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>25</b>
<b>26</b>	<b>27</b>	<b>28</b>	<b>29</b>	<b>30</b>  <b>17:00-21:00 H1</b>		









December 2011

Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
					1	2
3	4  17:00-21:00	5  9:00 a.m.13:00. p.m. 17:00-21:00	6  17:00-21:00	7  9. a.m.-13:00 p.m.	8	9
10  9. a.m.-13:00 p.m.	11  9. a.m.-13:00 p.m. 13:00-17:00 p.m.	12  9. a.m.-13:00 p.m. & 13:00-17:00 p.m.	13  9. a.m.-13:00 p.m. & 13:00-17:00 p.m.	14  9. a.m.-13:00 p.m.	15	16
 17:00-21:00	 17:00-21:00		 17:00-21:00			



**January 2012**

Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
	<p>1</p>  <p>9. a.m.-13:00 p.m. 13:00-17:00 p.m.</p>	<p>2</p>  <p>9. a.m.-13:00 p.m.</p>	<p>3</p>  <p>9. a.m.-13:00 p.m.</p>	<p>4</p>  <p>9. a.m.-13:00 p.m.</p>	5	6
<p>7</p>  <p>9. a.m.-13:00 p.m. 13:00-17:00 p.m.</p>	<p>8</p>  <p>9. a.m.-13:00 p.m.</p>	<p>9</p>  <p>9. a.m.-13:00 p.m. 13:00-17:00 p.m.</p>	10	<p>11</p>  <p>9. a.m.-13:00 p.m. 13:00-17:00 p.m.</p>	12	13
<p>14</p>  <p>=9. a.m.- 13:00 p.m.</p>	<p>15</p>  <p>=9. a.m.- 13:00 p.m. 13:00-17:00 p.m.</p>	16	17	<p>18</p>  <p>9. a.m.-13:00 p.m.</p>	19	20

<p>21</p>  <p>9. a.m.-13:00 p.m.</p>	<p>22</p>  <p>9. a.m.-13:00 p.m. 13:00-17:00 p.m.</p>	<p>23</p>	<p>24</p>	<p>25</p>  <p>9. a.m.-13:00 p.m.</p>	<p>26</p>	<p>27</p>
<p>28</p>  <p>9. a.m.-13:00 p.m.</p>	<p>29</p>  <p>9. a.m.-13:00 p.m.</p>	<p>30</p>  <p>9. a.m.-13:00 p.m.</p>	<p>31</p>			

### Appendix 9: List of Abbreviations

<b>Code</b>	<b>Description</b>
CA	Conversation analysis
Cl	Clinic type
Chemo. Cl.	Chemotherapy clinic
Haem. Cl.	Haematology clinic
Surg. On. Cl	Surgical oncology clinic
D	Day of visit
Da.	Date of visit
D./Dr:	Doctor
Dr1:	First doctor 1 usually the consultant
Dr2:	The second doctor, usually the resident or the specialist
E	Number of the extract
F.Ch.	Female chaperone
FPP	A first pair part (FPP) (e.g. a question)
H1	Hospital one
H2	Hospital two
H3	Hospital three
IJMES	International Journal of Middle East Studies
[K+]	More knowledgeable or knowing position
[K-]	Less knowledgeable or unknowing position
M.Ch.	Male chaperone
MOH	Ministry of Health
MS	Microsoft
N.	Nurse
NHS	National Health Service (NHS)
PSQ	Patient satisfaction questionnaire
P/Pt.	Patient
Radio-th	Radiotherapy

Res.	Researcher
SD	Standard derivation
SEIT	Scottish Ethnomethodology, Discourse, Interaction & Talk (Group)
SPP	Second pair part, (e.g. an answer).
SPSS	Statistical Package for Social Sciences
TCUs	Turn constructional units
V	Voice number file
Vs.	Versus (i.e. against)

## Appendix 10: Transcription conventions

Transcription conventions in this thesis are mainly based on the transcript system developed by Gail Jefferson's system (1985, 2004) and used later by conversation analysts (Heritage & Atkinson, 1984; Ten Have & Psathas, 1995). In transcribing the three-party interaction, a fixed layout is adopted as follows. Each line is numbered at the left-hand margin. Plenty of space was left between the speakers initial and their utterance. The speaker initial at the beginning of the turn is used to indicate who is talking (e.g. Dr.= doctor, Pt = patient, F.Ch = female chaperone, M.Ch = male chaperone). Participants' names have been changed to preserve their identity.

Symbol	Name	Use
[	A single left bracket	Indicates the points at which utterance overlaps.
]	A single right bracket	Shows the point at which overlap ends in the speaker's utterance.
=	Equal signs	(One at the end of a turn and one at the beginning of the next turn) indicates a latching between the turns without any gap or pauses.
?	Question mark	Indicates a rising intonation.
::	Colons	Indicates a stretch of the immediately prior sound. Additional colons indicate a more stretched sound over a long period.
.	Period /full stop	Indicates a stopping fall in tone, giving some sense of completion but not necessarily the end of the sentence.
-	Dash	Indicates a cut-off either because of an interruption or self-repair.
< text >	Right carets	Indicates that the enclosed utterance is delivered more slowly than the surrounding talk.
>text <	Left carets	Indicates that the enclosed utterance is delivered more quickly than the surrounding talk.

text	The degree sign	Indicates that part of the utterance bracketed by degree signs is quieter than the surrounding talk.
	Upward arrow	Indicates a marked higher pitch.
	Downward arrow	Indicates a marked lower pitch.
WORD	Upper case	Indicates that part of the utterance is louder than the surrounding talk.
<u>word</u>	Underscoring	Indicates some kind of stress via pitch.
huh/heh		Indicates laughter.
hhh		Indicates exhalation/breathing out.
£	Smile voice	Indicates that the speaker is smiling while speaking.
.hhh	A dot-prefixed row of hs	Indicates inhalation/breathing in.
w(h)ord	A parenthesised h	Indicates breathiness.
(.)	A dot in parentheses	Indicates a tiny pause (around a tenth of a second) within and between turns.
(( ))	Double parentheses	Contain transcriber's descriptions and comments.
( )	Empty parentheses	Indicate transcriber's inability to hear a stretch of utterance.
(word)	Parenthesised words	Indicate transcriber's doubts.
	Creaky voice	Indicates rasping or 'creaky voice' quality.



## Appendix 11

### IJMES transliteration system of Arabic consonants<sup>108</sup> and vowels

#### First: Arabic consonants

Consonant	Symbol	Description	Example
		Voiced glottal stop	/ anba / (news/
	b	Voiced bilabial stop	/ba b/ (door)
	t	Voiceless dentoalveolar stop	/tamr/ (dates)
	th	Voiceless inter-dental fricative	/thaqi l/ (heavy)
	j	Voiced post-alveolar affricate	/jami l/ (beautiful)
		Voiceless pharyngeal fricative	/ adi qah/ (garden)
	kh	Voiceless uvular fricative	/khaliyyaa <sup>2</sup> / (net)
	d	Voiced dento-alveolar stop	/damm/ (blood)
	dh	Voiced alveolar fricative	/dhahb/ (gold)
	r	Voiced alveo-palatal trill	/raml/ (sand)
	z	Voiced alveolar fricative	/zabi b/ (raisin)
	s	Voiceless alveolar fricative	/samma / (sky)
	sh	Voiceless alveo-palatal fricative	/shir/ (poetry)
		Voiceless alveolar emphatic fricative	/ adi q/ (friend)
		Voiced alveolar emphatic stop	/ aba b/ (fog)
		Voiceless dento-alveolar stop	/ awi l/ (tall)
		Voiced alveolar emphatic fricative	/ ulm/ (injustice)
		Voiced pharyngeal fricative	/ amal/ (work)
	gh	Voiced uvular fricative	/gha bah/ (jungle)
	f	Voiceless labio-dental fricative	/fa ris/ (knight)
	q	Voiced uvular stop	/qal ah/ (castle)

<sup>108</sup> I have modified the IJMES transliteration system because I noticed that most male doctors are Egyptians and they pronounce j as g, and q as hamza ( ). So, in transcribing their speech, I use g instead of j and ( ) instead of q.

	k	Voiceless velar stop	/Karaz/ (cherries)
	l	Voiced alveolar lateral	/laymu n/ (lemon)
	m	Voiced bilabial nasal	/mifta / (a key)
	n	Voiced alveolar nasal	/na fidhah/ (window)
	h	Voiceless glottal fricative	/hawa / (air)
	w	Voiced labio-velar glide	/ward/ (roses)
	y	Voiced palatal glide	/yati m/ (orphan)
	a <sup>2</sup>	A variant of /t/ and a suffix used to form feminine words.	/madrasaa <sup>2</sup> / (school)
	<sup>3</sup>	(definite article)	/ <sup>3</sup> qamar/ (the moon)
		Double consonant	/Rabba/ (bring up)

### Second: Arabic vowels:

Short vowels	Symbol	example
- ( )	a	/qara a/ (he reads)
- ( )	u	/dumyah/ (a doll)
- ( )	i	/qi ah/ (a story)

### Long vowels

Long vowels	Symbol	example
ى		/qa l/ (he said)
		/mulu k/ (kings)
		/qam / (t-shirt)

## Diphthongs

diphthongs	Symbol	example
اَی	au/aw	/yawm/ or /yaum/ (a day)
	ai/ay	/bait/ or /bayt/ (a house)

## Appendix 12: Patient satisfaction questionnaire (English version)



KING ABDULAZIZ UNIVERSITY



My name is Maha Al-ayyash, and I am a third year PhD student at Edinburgh University in the Linguistics and English Language Department, Scotland, United Kingdom. This study has been funded with the support of King Abdulaziz University and was approved by the Review Committee, Linguistics and English Language Department at the University of Edinburgh, and the Chairman of the Research Ethics Committee at the International Medical Centre. My research concentrates on the medical conversations between a male doctor, and a Saudi female patient along with her chaperone, and on the extent to which a female patient is satisfied with the medical consultation process and her chaperone's role within it. Thank you for agreeing to have your consultation recorded. In order to complete this research, I would like to know how you felt the consultation went, and how you felt about the presence of your chaperone. I would be very grateful if you could take 5 minutes to complete this short questionnaire. Remember, your answers will be treated with complete confidentiality, and will be linked to the recording by code to preserve anonymity. Your answers will be used only for research purposes. In addition, the questionnaire will be destroyed after my research is completed. If you finished completing the questionnaire, please hand it to me. Or you may place it in the collection box in the female waiting area of the hospital.

## Patient satisfaction questionnaire on MEDICAL CONSULTATION and PATIENT'S CHAPERONE

### Section 1 (about the PATIENT)

#### Fill in responses

1.1. Clinic: \_\_\_\_\_

1.2. Age: \_\_\_\_\_

1.3. Level of Education: (**which best describes the highest level you studied at: Please tick one box**)

- Did not attend school
- Illiterate school<sup>109</sup>
- Elementary
- Intermediate
- High school
- Diploma
- University
- Postgraduate

1.4. Marital Status: (**Please tick one box**)

- Single
- Married
- Separated

---

<sup>109</sup> A school for people who are illiterate.

- Divorced
- Widowed

1.5. Type of visit: **(Please tick one box)**

- New
- Follow up

**Section 2 (Concerning patient's chaperone)**

2.1. Your chaperone's gender today is: **(Please fill in response)**

\_\_\_\_\_

2.2. Your chaperone's age: \_\_\_\_\_ (Please fill in response)

2.3. His/her relation to you: \_\_\_\_\_ (Please fill in response)

2.4. Your chaperone's level of education (**which best describes the highest level your chaperone studied at**)

- Did not attend school
- Illiterate school
- Elementary
- Intermediate
- High school
- Diploma
- University
- Post graduate

**Section 3 (Medical visit)**

Please read each statement carefully and **MARK ONLY ONE BOX ON EACH ROW. IF YOU MAKE A MISTAKE, CROSS IT OUT AND MARK YOUR PREFERRED ANSWER CLEARLY.** Choose the opinion which is closest to your own, keeping in your mind all aspects of today’s medical visit, from the start of the medical conversation until it ended.

**How strongly do you AGREE or DISAGREE with each of the following statements? (MARK ONLY ONE BOX ON EACH ROW)**

**3.1. Rating the care provided by the physician**

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
	5	4	3	2	1
1. My doctor treated me with respect.					
2. My doctor gave me enough time to describe my health problem.					
3. My doctor listened to what I was saying.					
4. My doctor encouraged me to talk and ask questions.					

### 3.2. Rating the care provided by chaperone

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
	5	4	3	2	1
1. My chaperone treated me with respect.					
2. My chaperone gave me enough time to describe my health problem.					
3. My chaperone encouraged me to talk and ask questions.					
4. My chaperone clarified some information about me to my doctor.					

### 3.3. Rating the patient-chaperone relationship

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
	5	4	3	2	1
1. I felt comfortable talking to my doctor in front of my chaperone.					
2. I consider my chaperone and myself as one.					



### 3.4. Rating the impact of the chaperone's involvement on doctor-patient interaction

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
	5	4	3	2	1
1. Sometimes, I felt that my doctor focused his attention on my chaperone rather than me.					
2. There were some issues that I would have liked to tell my doctor about, but I could not.					
3. Sometimes, I felt that I was excluded from the conversation.					

### 3.5. Rating the effect of attending the consultation alone

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
	5	4	3	2	1
1. If my circumstances permitted, I would prefer to attend the medical consultation on my own.					

### 3.6. Rating the chaperone's role in the consultation room

	Strongly Agree	Agree	Uncertain	Disagree	Strongly disagree
	5	4	3	2	1
1. My chaperone did not play a big part.					

### Section 4 (open-ended question)

4.1. How would you rate your chaperone's behaviour during the consultation?

4.2. Overall, what (if anything) was **GOOD** about having your chaperone with you?

4.3. Overall, what (if anything) **was not GOOD** about having your chaperone with you?

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4.4. If you have any additional comments regarding male or female chaperones please write them below:

**Section 5 (Please mark one box on each line)**

	YES	NO	Not sure
1. Overall, were you satisfied with the interaction between your doctors, your chaperone, and yourself?			
2. Would you choose your chaperone again if you had to have another medical consultation (if possible)?			

Thank you for completing this questionnaire. Please feel free to contact me if you have any queries on the following email:

[M.Al-Ayyash@sms.ed.ac.uk](mailto:M.Al-Ayyash@sms.ed.ac.uk)

## Appendix 12a: Questionnaire data (Arabic version)



اسمي مها العياش طالبة دكتوراة في السنة الثالثة بجامعة ادنبرة بقسم اللغويات و اللغة الانجليزية في اسكتلندا, . تم تمويل هذه الدراسة بدعم من جامعة الملك عبدالعزيز و تمت الموافقة عليها من قبل لجنة البحوث بقسم اللغويات واللغة الانجليزية بجامعة ادنبرة و رئيس لجنة اخلاقيات البحوث الطبية في الـ الذي يتم بين الطبيب و المريضة السعودية و مرافقها سواء اكان رجلاً ام امرأة و مدى رضى المريضة عن الزيارة الطبية و دور مرافقها اثناء . بتسجيل الحوار الطبي ولكي يكتمل هذا البحث على الوجه المطلوب, اتمنى ان اعرف كيف احسست اثناء العيادة ذهبتى اليها وكيف شعرت عند حضور مرافقك معك. شاكراة إذا تكرمتي بتعبئة هذا الاستبيان القصير والذي سوف يستغرق كماله. اود ان انوه هنا سوف يتم التعامل مع إجاباتك بسرية كاملة ، وسوف يتم ربطها مع التسجيلات الصوتية برمز للحفاظ علي عدم الكشف عن هويتك. وسيتم استخدام اجاباتك فقط لأغراض بحثية . وبالإضافة إلى ذلك، سيتم يتم اتلاف هذا الاستبيان بعد مناقشة هذا البحث باذن الله. ذا اكملت الأستبيان, ارجو تسليمه لي او بامكانك وضعه في الصندوق المخصص لجمع الأستبيان في المنطقة المخصصة لأنتظار السيدات.

استبيان عن رضى المرضى على

مرافق المريضة

**( عن المريضة ) :**

املء الفراغات الاتية من فضلك:

. العيادة : \_\_\_\_\_

. \_\_\_\_\_:

. المستوى التعليمي: (الرجاء اختيار اجابة و احدة )

مدرسة محو الامية

ثانوية

دراسات عليا

. الحالة الاجتماعية: (الرجاء اختيار اجابة و احدة )

. نوع الزيارة للعيادة : (الرجاء اختيار اجابة و احدة)

جديدة

: (عن مرافق او مرافقة المريضة)

. مرافقك اليوم : ( )

---

. : ( )

. صلة القرابة للمريضة: ( )

. . المستوى التعليمي للمرافق: ( اختيار اجابة و احدة )

مدرسة محو الامية

ثانوية

دراسات عليا

( ) :

( )

( )  
أختيار الرأي الأقرب لك, مع الأخذ في الأعتبار جميع جوانب الحوار الطبي منذ بدء المحادثة و حتى نهايتها.

الى اي درجة توافقين او تختلفين مع كل عبارة من العبارات الاتية. ( )

تقييم الرعاية المقدمة من الطبيب

		غير متأكدة			
					طبيبي بكل احترام.
					اعطاني طبيبي وقتاً كافياً لوصف مشكلتي الصحية.
					كان طبيبي ينصت الى ما كنت اقلوه
					شجعني طبيبي على ان اتكلم واطرح الاسئلة المتعلقة بحالتي الصحية.



تقييم الرعاية المقدمة من الـ

		غير متأكدة			
					.
					ي وقتاً كافياً لوصف مشكلتي الصحية.
					شجعني مرافقي على ان اتكلم واطرح الاسئلة المتعلقة بحالتي الصحية.
					.

تقييم الرعاية العلاقة بين المريض و المرافق

		غير متأكدة			
					كنت مرتاحة عند التحدث مع طبيبي امام مرافقي.
					.

تقييم اثر مشاركة المرافق في الحوار بين الطبيب والمريض

		غير متأكدة			
					. شعرت في بعض الاحيان ان طبيبي يركز اهتمامه على مرافقي بدلاً مني.
					. كان بودي ان اخبر طبيبي عن بعض الامور ولكني لم استطع.
					. شعرت في بعض الاحيان بأنني خارج نطاق الحديث او تم استبعادني من .

تقييم اثر حضور المريضة للعيادة بمفردها

		غير متأكدة			
					. ( ) ان احضر للعيادة بمفردي.

تقييم دور المرافق في العيادة

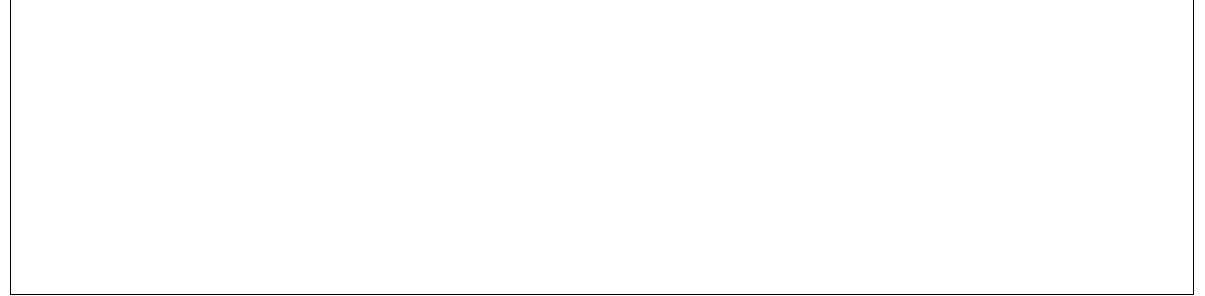
		غير متأكد			
					لم يتم مرافقي باي دور.

\_\_\_\_\_:

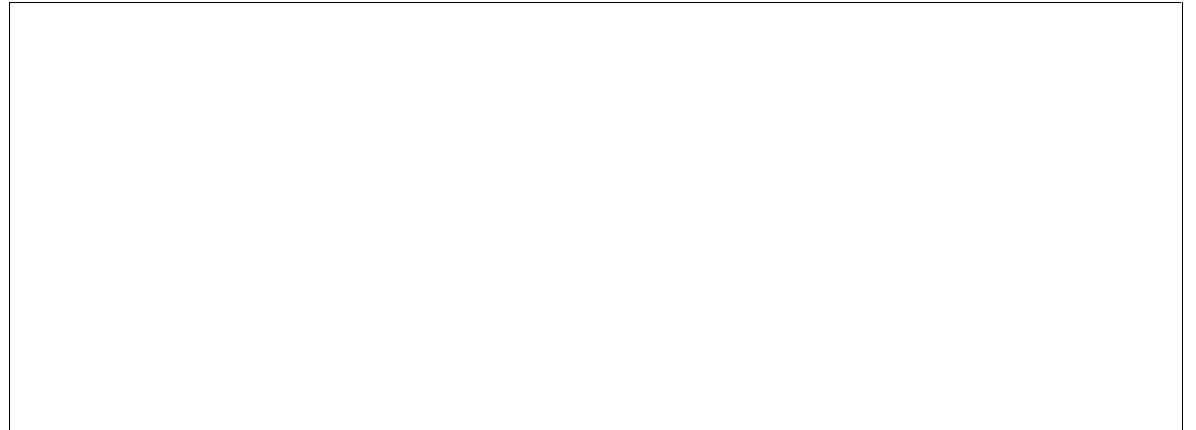
كيف تصفين دور مرافقك اثناء العيادة؟

عموما ماهي الاشياء الايجابية ( التي قام بها معك؟

. عموماً ماهي الأشياء السلبية ( ) التي قام بها معك؟



. إذا كان لديك أي تعليقات إضافية بخصوص المرافق أو المرافقة، الرجاء كتابتها في المربع أدناه.



الجزء الخامس و الاخير: (الرجاء الاجابة على هذين السؤالين بوضع علامة (

غير متاكدة			
			هل انت راضية عن المحادثة التي تمت بوجود مرافقي و طبيبي و انا ايضا؟
			. هل سوف تختارين مرافقك ( ) مرة اخرى اذا ذهبت مرة اخرى الى العيادة؟

اشكرك على ملء هذا الاستبيان. اذا كان لديك اي استفسار يمكنك التواصل معي على هذا الايميل [M.Al-Ayyash@sms.ed.ac.uk](mailto:M.Al-Ayyash@sms.ed.ac.uk)

### Appendix 13: Coding for the questionnaire data

For the questionnaire data in this study, the following codes were used:

1. **Clinic:** Chemotherapy = 1, Haematology = 2, Radiotherapy = 3, Surgical Oncology = 4, Nuclear Medicine = 5, Orthopaedic Surgery = 6, and General Surgery = 7
2. **Level of Education:** did not attend school = 1, Illiterate school = 2, Elementary = 3, Intermediate = 4, High school = 5, University = 6, Diploma = 7, and Post graduate = 8
3. **Marital Status:** Single = 1, Married = 2, Separated = 3, Divorced = 4, and Widowed = 5
4. **Type of visit:** New = 1 and Follow up = 2
5. **Chaperone gender** attending the consultation with the patient: 0 = Male, 1 = Female, Male and female = 2, and Group = 3
6. **Chaperone relation to the patient:** father = 1, mother = 2, husband = 3, brother = 4, sister = 5, son = 6, daughter = 7, niece = 8, relative = 9, son and daughter = 10, father and sister = 11, husband and his second wife = 12, and brother, son, and daughter = 13
7. **Likert scale:** two different scales were used (1) strongly agree = 5 to strongly disagree = 1 and (2) strongly disagree = 5 to strongly agree = 1
8. **Rating chaperones' attitudes:** Positive = 1 and Negative = 2
9. **Scale:** Yes = 1, No = 2 and not sure = 3
10. **Filling the questionnaire:** self = 1, and assisted = 2

### Appendix 14: The three main identified themes with some examples from the data

<p style="text-align: center;"><b>Emotional support</b></p> <p style="text-align: center;"><b>Related codes</b> (help, support/stand, amuse, comfort, presence, ease, relax me, reassured me)</p>	<p style="text-align: center;"><b>Informational support</b></p> <p style="text-align: center;"><b>Related codes</b> (talk, behalf, tell, speak, clarify, remind me)</p>	<p style="text-align: center;"><b>Logistical support</b></p> <p style="text-align: center;"><b>Related codes</b> (drive/take/ helped with transport, organise/arrange my appointment- washed me/ dressed me up)</p>
<p><b>I. Comfort of the chaperone's physical presence</b></p> <p>(P58, Age: 64, illiterate, Chaperone: son). 'I felt relaxed and comfortable when my son accompanied me.'</p> <p><b>II. Comfort of the chaperone's verbal reassurance</b></p> <p>(P18, Age, 51, University, Chaperone: husband). 'I feel psychological comfort. I feel comfortable with my husband; he reassured me.'</p>	<p><b>I. Advocacy role (speaking for the patient)</b></p> <p>(P55, Age: 21, Secondary school, Chaperone: husband). 'He spoke on my behalf today. I feel shy when I speak to the male doctor. I let him speak on my behalf. If he makes a mistake, I will correct him.'</p> <p><b>II. Memory aid</b></p> <p>(P16, Age: 69, illiterate, Chaperone: daughter). 'She reminds me of the medication's name.'</p>	<p><b>I. Transport</b></p> <p>(P2, Age: 50, illiterate, Chaperone: son). 'He drove me to the hospital.'</p> <p><b>II. Physical support</b></p> <p>(P20, Age: 57, illiterate, chaperone: daughter). 'She arranges the appointment.'</p> <p>(P43, Age: 37, intermediate school, chaperone: daughter). 'She is close to me, dresses me up, helps me shower.'</p>

*Note:* themes that are repeated many times are shown in bold. Themes that are mentioned few times are shown in plain type.

**Appendix 15: Gender variation with regards to emotional support (as an example)**

<b>Emotional Support</b>	
<b>Male</b>	<b>Female</b>
<p><b>I. Comfort with physical presence</b></p> <p>(P58, Age: 64, illiterate, Chaperone: son). ‘I feel relaxed and comfortable when my son accompanied me.’</p> <p>(P51, Age: 45, illiterate, Chaperone: son). ‘I feel relaxed when somebody is with me inside the clinic, close to me, my son is my friend, amuses me, stands beside me.’</p> <p>(P78, Age: 42, University, Chaperone: husband). ‘I feel comfortable with him. I do not want to feel lonely.’</p> <p><b>II. Comfort with verbal reassurance</b></p> <p>(P18, Age, 51, University, Chaperone: husband). ‘I feel psychological comfort. I feel comfort with my husband, he reassured me.’</p> <p>(P52, Age: 30, Secondary school, Chaperone: son). ‘I feel safe in case I have to face any problems, he makes things easier for me.’</p> <p>(P101, Age: 42, University, Chaperone: son). When I heard something harsh from the doctor, the presence of my son put everything at ease. He helped me to calm down.’</p>	<p><b>I. Comfort with physical presence</b></p> <p>(P20, Age: 57, illiterate, Chaperone: daughter). ‘Her presence comforted me. She made me relaxed.’</p> <p>(P23, Age: 56, Intermediate school, Chaperone: sister). ‘I feel comfortable and relaxed with my sister’s presence.’</p> <p>(P25, Age: 20, University, Chaperone: mother). She accompanied me to the clinic. I feel comfortable with her presence.</p> <p><b>II. Comfort with verbal reassurance</b></p> <p>(P32, Age: 31, Secondary school, Chaperone: sister). She reassured me today when the doctor had bad news about my x-ray result.</p> <p>(P36, Age: 50, illiterate, chaperone: daughter). ‘I feel comfortable with my daughter’s verbal support. She reassured me. She calms me down when I hear something bad about my health.’</p> <p>(P38, Age: 38, Elementary school, Chaperone: daughter). ‘She supported me. She strengthened me, reassured me when I heard something harsh from the doctor.’</p>



## Appendix 16: Preparing the qualitative data for thematic analysis

Patient No.	Quotes	Codes	Analytic memos
P1. age: (45) Ed: Illiterate Female relative	انها ساعدتني و تتكلم مع الدكتور بالنيابة عني She helps me, she speaks on my behalf	انها ساعدتني و تتكلم مع الدكتور بالنيابة عني  She helps <sup>1</sup> me she speaks on my behalf <sup>2</sup>	<ul style="list-style-type: none"> <li>• Verbal support, the female relative played an advocate role (speaking for the patient).</li> </ul>
P2. Age: 50, Ed. illiterate (son)	انه وصلني للمستشفى. ارتاح لما يكون ولدي He drove me to the hospital I feel comfortable when my son accompanies me	انه وصلني للمستشفى . لما يكون ولدي معي He drove <sup>1</sup> me to the hospital I feel comfortable when my son accompanies me	<ul style="list-style-type: none"> <li>• Physical support (logistical)</li> <li>• Psychological comfort (physical presence)</li> </ul>

Patient No.	Quotes	Codes	Analytic memos
P3. Age:65 Ed. Illiterate Son	<p>انه وضع للدكتور وتكلم مع الدكتور اليوم            Today, he clarified things and spoke to the doctor.</p> <p><b><u>Additional comments</u></b></p> <p>My son spoke to the doctor on my behalf (repeated)</p>	<p>اليوم انه وضع للدكتور            He clarified<sup>1</sup> and spoke<sup>2</sup> to the doctor</p>	<ul style="list-style-type: none"> <li>• The patient's son played an advocate role (speaking for the patient, clarifying some medical information about the patient.)</li> <li>• Additional comment (repeated).</li> </ul>

## Appendix 17

A detailed list of audio-recorded files collected from three hospitals in Jeddah, Saudi Arabia<sup>110</sup>

Hospital	Patient Number	Clinic	Date	Days	Time	Voice file number	Visit number	Length	Name
H1	108	Surgical orthopaedic	30.11.2011	Wednesday. Day 1	5:00 p.m.- 9:00 p.m.	Voice1	1	23.54	H1D1V1V1
	114	Surgical oncology	30.11.2011	Wednesday. Day 1	5:00 p.m.- 9:00 p.m.	-	1	-	-
	103	General surgery	5.12.2011	Monday Day2	9:00 a.m.	Voice2	2	8.09	H1D2V2V2
	110	Surgical orthopaedic	5.12.2011	Monday Day2	5:00 p.m.- 9:00 p.m.	Voice3	2	2.03	H1D2V3V2
	112	Surgical orthopaedic	5.12.2011	Monday Day2	5:00 p.m.- 9:00 p.m.	Voice4	2	12.21	H1D2V4V2
	113	Surgical orthopaedic	5.12.2011	Monday Day2	5:00 p.m.- 9:00 p.m.	Voice5	3	10.12	H1D2V5V3
	104	Chemotherapy	6.12.2011	Tuesday Day3	5:00 p.m.- 9:00 p.m.	Voice6	2	24.72	H1D3V6V2
	109	Surgical orthopaedic	6.12.2011	Tuesday Day3	5:00 p.m.- 9:00 p.m.	Voice7	3	4.1	H1D3V7V3
	107	Surgical orthopaedic	10.12.2011	Saturday Day4	5:00 p.m.- 9:00 p.m.	Voice8	4	26.49	H1D4V8V4
	111	Surgical orthopaedic	10.12.2011	Saturday Day4	5:00 p.m.- 9:00 p.m.	Voice9	4	8.55	H1D4V9V4
	115	Surgical oncology	10.12.2011	Saturday Day4	5:00 p.m.- 9:00 p.m.	-	4	-	-

<sup>110</sup> Seven audio-recorded files were disregarded as the voices of the participants were not clear.

Hospital	Patient Number	Clinic	Date	Days	Time	Voice file number	Visit number	Length	Name
H1	105	Radiotherapy	11.12.2011	Sunday Day5	5:00 p.m.- 9:00 p.m.	Voice10	5	18.59	H1D5V10V5
	106	Chemotherapy	13.12.2011	Tuesday Day6	5:00 p.m.- 9:00 p.m.	Voice11	6	28.45	H1D6V11V6

### A detailed list of audio-recorded files

Hospital	Patient Number	Clinic	Date	Days	Time	Voice file number	Visit number	Length	Name
H2	116	Surgical orthopaedic	4.12.2011	Sunday Day1	5:00 p.m.-9:00 p.m.	Voice1	1	13.01	H2D1V1V1
	117	Surgical orthopaedics	4.12.2011	Sunday Day1	5:00 p.m.-9:00 p.m.	Voice2	1	6.95	H2D1V2V1

### A detailed list of audio-recorded files

Hospital	Patient Number	Clinic	Date	Days	Time	Voice file number	Visit number	Length	Name
H3	96	Haematology	7.12.2011	Wednesday. Day 1	9:00 a.m.- 1:00 p.m.	-	1	-	-
	88	Chemotherapy	7.12.2011	Wednesday. Day 1	9:00 a.m.- 1:00 p.m.	Voice1	1	10.24	H3D1V1V1
	87	Radiotherapy	10.12.2011	Saturday Day2	9:00 a.m.- 1:00 p.m.	Voice2	2	9.28	H3D2V2V2
	89	Haematology	11.12.2011	Sunday Day3	9:00 a.m.- 1:00 p.m.	Voice3	3	13.41	H3D3V3V3
	48	Surgical oncology	11.12.2011	Sunday Day3	1:00 p.m.- 5:00 p.m..	Voice4	3	15.14	H3D3V4V3
	77	Surgical oncology	12.12.2011	Monday Day4	1:00 p.m.- 5:00 p.m.	Voice5	4	15.15	H3D4V5V4
	90	Radiotherapy	12.12.2011	Monday Day4	9:00 a.m.- 1:00 p.m.	Voice 6	4	8.55	H3D4V6V4
	78	Chemotherapy	13.12.2011	Tuesday Day5	9:00 a.m.- 1:00 p.m.	Voice7	5	18.41	H3D5V7V5
	85	Surgical oncology	13.12.2011	Tuesday Day5	1:00 p.m.- 5:00 p.m.	Voice8	5	6.01	H3D5V8V5
	67	Chemotherapy	14.12.2011	Wednesday Day6	9:00 a.m.- 5:00 p.m.	Voice9	6	3.03	H3D6V9V6
	68	Chemotherapy	14.12.2011	Wednesday Day6	9:00 a.m.- 5:00 p.m.	Voice10	6	9.39	H3D6V10V6
	69	Chemotherapy	17.12.2011	Saturday Day7	9:00 a.m.- 5:00 p.m.	Voice11	7	82.29	H3D7V11V7
	1	Surgical oncology	18.12.2011	Sunday Day8	1:00 p.m.- 5:00 p.m.	Voice12	8	20.03	H3D8V12V8
	12	Chemotherapy	18.12.2011	Sunday Day8	9:00 a.m.- 5:00 p.m.	Voice13	8	14.36	H3D8V13V8

### A detailed list of audio-recorded files

Hospital	Patient Number	Clinic	Date	Days	Time	Voice file number	Visit number	Length	Name
H3	9	Chemotherapy	19.12.2011	Monday Day9	9:00 a.m.-5:00 p.m.	Voice 14	9	7.29	H3D9V14V9
	70	Surgical oncology	19.12.2011	Monday Day9	1:00 p.m.-5:00 p.m.	Voice15	9	11.35	H3D9V15V9
	71	Surgical oncology	19.12.2011	Monday Day9	1:00 p.m.-5:00 p.m.	Voice16	9	3.37	H3D9V16V9
	84	Radiotherapy	19.12.2011	Monday Day9	9:00 a.m.-5:00 p.m.	Voice17	9	5.18	H3D9V17V9
	99	Chemotherapy	19.12.2011	Monday Day9	9:00 a.m.-5:00 p.m.	Voice18	9	21.14	H3D9V18V9
	72	Chemotherapy	20.12.2011	Tuesday Day10	9:00 a.m.-5:00 p.m.	Voice19	10	24.72	H3D10V19V1 0
	73	Chemotherapy	20.12.2011	Tuesday Day10	9:00 a.m.-5:00 p.m.	Voice20	10	16.23	H3D10V20V1 0
	18	Chemotherapy	21.12.2011	Wednesday Day11	9:00 a.m.-5:00 p.m.	Voice21	11	6.28	H3D11V21V1 1
	47	Chemotherapy	21.12.2011	Wednesday Day11	9:00 a.m.-5:00 p.m.	Voice22	11	18.41	H3D11V22V1 1
	79	Chemotherapy	21.12.2011	Wednesday Day11	9:00 a.m.-5:00 p.m.	Voice23	11	19.49	H3D11V23V1 1
	92	Chemotherapy	21.12.2011	Wednesday Day11	9:00 a.m.-5:00 p.m.	Voice24	11	4.13	H3D11V24V1 1
	93	Chemotherapy	21.12.2011	Wednesday Day11	9:00 a.m.-5:00 p.m.	Voice25	11	4.45	H3D11V25V1 1
	95	Chemotherapy	21.12.2011	Wednesday Day11	9:00 a.m.-5:00 p.m.	Voice26	11	15.66	H3D11V26V1 1
	19	Chemotherapy	24.12.2011	Saturday Day12	9:00 a.m.-5:00 p.m.	Voice 27	12	11.35	H3D12V27V1 2

### A detailed list of audio-recorded files

Hospital	Patient Number	Clinic	Date	Days	Time	Voice file number	Visit number	Length	Name
H3	44	Chemotherapy	24.12.2011	Saturday Day13	9:00 a.m.-5:00 p.m.	Voice28	13	5.51	H3D13V28I3
	74	Chemotherapy	24.12.2011	Saturday Day13	9:00 a.m.-5:00 p.m.	Voice29	13	11.19	H3D13V29V13
	3	Haematology	25.12.2011	Sunday Day14	9:00 a.m.-5:00 p.m.	Voice30	14	2.32	H3D14V30V14
	45	Nuclear medicine	25.12.2011	Sunday Day14	9:00 a.m.-5:00 p.m.	Voice31	14	9.11	H3D14V31V14
	46	Surgical oncology	25.12.2011	Sunday Day14	1:00 p.m.-5:00 p.m.	Voice32	14	4.05	H3D14V32V14
	80	Surgical oncology	25.12.2011	Sunday Day14	9:00 a.m.-5:00 p.m.	Voice33	14	18.38	H3D14V33V14
	86	Surgical oncology	25.12.2011	Sunday Day14	1:00 p.m.-5:00 p.m.	Voice34	14	18.38	H3D14V34V14
	10	Surgical oncology	26.12.2011	Monday Day15	1:00 p.m.-5:00 p.m.	Voice35	15	7.29	H3D15V35V15
	42	Surgical oncology	26.12.2011	Monday Day15	1:00 p.m.-5:00 p.m.	Voice36	15	3.34	H3D15V36V15
	43	Surgical oncology	26.12.2011	Monday Day15	1:00 p.m.-5:00 p.m.	Voice37	15	6.59	H3D15V37V15
	97	Surgical oncology	26.12.2011	Monday Day15	1:00 p.m.-5:00 p.m.	Voice38	15	8.43	H3D15V38V15
	98	Surgical oncology	26.12.2011	Monday Day15	1:00 p.m.-5:00 p.m.	Voice39	15	1.56	H3D15V39V15
	56	Chemotherapy	27.12.2011	Tuesday Day16	9:00 a.m.-5:00 p.m.	Voice40	16	11.41	H3D16V40V16
	57	Chemotherapy	27.11.2011	Tuesday Day16	9:00 a.m.-5:00 p.m.	Voice41	16	24.45	H3D16V41V16

### A detailed list of audio-recorded files

Hospital	Patient Number	Clinic	Date	Days	Time	Voice file number	Visit number	Length	Name
H3	55	Chemotherapy	28.12.2011	Wednesday Day17	9:00 a.m.-5:00 p.m.	Voice42	17	10.4	H3D17V42V17
	81	Chemotherapy	28.12.2011	Wednesday Day17	9:00 a.m.-5:00 p.m.	Voice43	17	15.03	H3D17V43V17
	82	Chemotherapy	28.12.2011	Wednesday Day17	9:00 a.m.-5:00 p.m.	Voice44	17	2.05	H3D17V44V17
	16	Chemotherapy	31.12.2011	Saturday Day18	9:00 a.m.-5:00 p.m.	Voice45	18	19.84	H3D17V45V18
	17	Chemotherapy	31.12.2011	Saturday Day18	9:00 a.m.-5:00 p.m.	Voice46	18	31.27	H3D18V46V18
	20	Chemotherapy	31.12.2011	Saturday Day18	9:00 a.m.-5:00 p.m.	Voice47	18	26.48	H3D18V47V18
	22	Chemotherapy	31.12.2011	Saturday Day18	9:00 a.m.-5:00 p.m.	Voice48	18	10.48	H3D18V48V18
	54	Chemotherapy	1.1.2012	Sunday Day19	9:00 a.m.-5:00 p.m.	Voice49	19	23.5	H3D19V49V19
	52	Surgical oncology	1.1.2012	Sunday Day19	1:00 p.m.-5:00 p.m.	Voice50	19	4.86	H3D19V50V19
	53	Chemotherapy	2.1.2012	Monday Day20	9:00 a.m.-5:00 p.m.	Voice51	20	6.59	H3D20V51V20
	100	Chemotherapy	2.1.2012	Monday Day20	9:00 a.m.-5:00 p.m.	Voice52	20	36.4	H3D20V52V20
	15	Chemotherapy	3.1.2012	Tuesday Day21	9:00 a.m.-5:00 p.m.	Voice53	21	22.49	H3D21V54V21
	50	Chemotherapy	3.1.2012	Tuesday Day21	9:00 a.m.-5:00 p.m.	Voice54	21	8.25	H3D21V54V21
	51	Chemotherapy	3.1.2012	Tuesday Day21	9:00 a.m.-5:00 p.m.	Voice55	21	24.09	H3D21V55V21



### A detailed list of audio-recorded files

Hospital	Patient Number	Clinic	Date	Days	Time	Voice file number	Visit number	Length	Name
H3	8	Chemotherapy	4.1.2012	Wednesday Day22	9:00 a.m.-5:00 p.m.	Voice56	22	6.25	H3D22V56V22
	11	Chemotherapy	4.1.2012	Wednesday Day22	9:00 a.m.-5:00 p.m.	Voice 57	22	18.13	H3D22V57V22
	48	Chemotherapy	4.1.2012	Wednesday Day22	9:00 a.m.-5:00 p.m.	Voice58	22	14.48	H3D22V58V22
	49	Chemotherapy	4.1.2012	Wednesday Day22	9:00 a.m.-5:00 p.m.	Voice59	22	7.36	H3D22V59V22
	66	Chemotherapy	4.1.2012	Wednesday Day22	9:00 a.m.-5:00 p.m.	Voice60	22	3.18	H3D22V60V22
	4	Haematology	7.1.2012	Saturday Day23	9:00 a.m.-5:00 p.m.	Voice 61	23	2.32	H3D23V61V23
	5	Chemotherapy	7.1.2012	Saturday Day23	9:00 a.m.-5:00 p.m.	Voice62	23	4.1	H3D23V62V23
	13	Chemotherapy	7.1.2012	Saturday Day23	9:00 a.m.-5:00 p.m.	Voice63	23	27.06	H3D23V63V23
	61	Surgical oncology	7.1.2012	Saturday Day23	1:00 p.m.-5:00 p.m.	Voice64	23	14.05	H3D23V64V23
	64	Chemotherapy	7.1.2012	Saturday Day23	9:00 a.m.-5:00 p.m.	Voice65	23	19.24	H3D23V65V23
	65	Chemotherapy	7.1.2012	Saturday Day23	9:00 a.m.-5:00 p.m.	Voice66	23	7.43	H3D23V66V23
	62	Chemotherapy	8.1.2012	Sunday Day24	9:00 a.m.-5:00 p.m.	Voice67	24	9.2	H3D24V67V24
	63	Chemotherapy	8.1.2012	Sunday Day24	9:00 a.m.-5:00 p.m.	Voice68	24	9.01	H3D24V68V24
	94	Radiotherapy	9.1.2012	Monday Day25	9:00 a.m.-5:00 p.m.	Voice69	25	14.11	H3D25V69V25

### A detailed list of audio-recorded files

Hospital	Patient Number	Clinic	Date	Days	Time	Voice file number	Visit number	Length	Name
H3	60	Surgical oncology	9.1.2012	Monday Day25	1:00 p.m.-5:00 p.m.	-	25	-	-
	40	Chemotherapy	11.1.2012	Wednesday Day26	9:00 a.m.-5:00 p.m.	Voice70	26	3.19	H3D26V70V26
	91	Chemotherapy	11.1.2012	Wednesday Day26	9:00 a.m.-5:00 p.m.	Voice71	26	8.59	H3D26V70V26
	58	Chemotherapy	11.1.2012	Wednesday Day26	9:00 a.m.-5:00 p.m.	Voice72	26	21.17	H3D26V72V26
	59	Chemotherapy	11.1.2012	Wednesday Day26	9:00 a.m.-5:00 p.m.	-	26	-	-
	102	Chemotherapy	11.1.2012	Wednesday Day26	9:00 a.m.-5:00 p.m.	Voice 73	26	9.04	H3D26V73V26
	41	Chemotherapy	14.1.2012	Saturday Day27	9:00 a.m.-5:00 p.m.	Voice74	27	11.13	H3D27V74V27
	30	Chemotherapy	14.1.2012	Saturday Day27	9:00 a.m.-5:00 p.m.	Voice75	27	9.2	H3D27V75V27
	31	Chemotherapy	14.1.2012	Saturday Day27	9:00 a.m.-5:00 p.m.	Voice76	27	14.45	H3D27V76V27
	32	Haematology	15.1.2012	Sunday Day28	9:00 a.m.-5:00 p.m.	Voice77	28	2.47	H3D28V77V28
	33	Haematology	15.1.2012	Sunday Day28	9:00 a.m.-5:00 p.m.	Voice78	28	7.33	H3D28V78V28
	34	Haematology	15.1.2012	Sunday Day28	9:00 a.m.-5:00 p.m.	Voice79	28	5.08	H3D28V79V28
	36	Haematology	15.1.2012	Sunday Day28	9:00 a.m.-5:00 p.m.	Voice80	28	3.27	H3D28V80V28
	35	Surgical oncology	15.1.2012	Sunday Day28	1:00 p.m.-5:00 p.m.	Voice81	28	8.28	H3D28V81V28

### A detailed list of audio-recorded files

Hospital	Patient Number	Clinic	Date	Days	Time	Voice file number	Visit number	Length	Name
H3	37	Surgical oncology	15.1.2012	Sunday Day28	1:00 p.m.-5:00 p.m.	Voice82	28	5.24	H3D28V82V28
	38	Haematology	18.1.2012	Wednesday Day29	9:00 a.m.-5:00 p.m.	Voice83	29	2.39	H3D29V83V29
	83	Haematology	18.1.2012	Wednesday Day29	9:00 a.m.-5:00 p.m.	Voice84	29	6.04	H3D29V84V29
	14	Chemotherapy	18.1.2012	Wednesday Day29	9:00 a.m.-5:00 p.m.	Voice85	29	27.1	H3D29V85V29
	26	Chemotherapy	21.1.2012	Saturday Day30	9:00 a.m.-5:00 p.m.	Voice86	30	14.29	H3D30V86V30
	27	Chemotherapy	21.1.2012	Saturday Day30	9:00 a.m.-5:00 p.m.	Voice87	30	15.03	H3D30V87V30
	101	Chemotherapy	22.1.2012	Sunday Day30	9:00 a.m.-5:00 p.m.	-	30	-	-
	39	Surgical oncology	22.1.2012	Sunday Day30	1:00 p.m.-5:00 p.m.	Voice88	30	9.35	H3D30V88V30
	25	Surgical oncology	22.1.2012	Sunday Day30	1:00 p.m.-5:00 p.m.	-	30	-	-
	75	Chemotherapy	25.1.2012	Wednesday Day31	9:00 a.m.-5:00 p.m.	Voice89	31	5.39	H3D31V89V31
	24	Haematology	25.1.2012	Wednesday Day31	9:00 a.m.-5:00 p.m.	Voice90	31	7.21	H3D31V90V31
	6	Chemotherapy	28.1.2012	Saturday Day32	9:00 a.m.-5:00 p.m.	Voice91	32	4.32	H3D32V91V32
	7	Haematology	28.1.2012	Saturday Day32	9:00 a.m.-5:00 p.m.	Voice92	32	4.32	H3D32V92V32
	23	Chemotherapy	28.1.2012	Saturday Day32	9:00 a.m.-5:00 p.m.	Voice93	32	6.04	H3D32V93V32

### A detailed list of audio-recorded files

Hospital	Patient Number	Clinic	Date	Days	Time	Voice file number	Visit number	Length	Name
H3	29	Chemotherapy	28.1.2012	Saturday Day32	9:00 a.m.-5:00 p.m.	Voice94	32	3.81	H3D32V94V32
	2	Chemotherapy	29.1.2012	Sunday Day33	9:00 a.m.-5:00 p.m.	Voice95	33	4.32	H3D33V95V33
	28	Chemotherapy	29.1.2012	Sunday Day33	9:00 a.m.-5:00 p.m.	Voice96	33	21.42	H3D33V96V33
	21	Chemotherapy	30.1.2012	Monday Day34	9:00 a.m.-5:00 p.m.	Voice97	34	8.27	H3D34V97V34

## Appendix 18: Transcripts of Three-party Medical Interactions

### Transcripts (Chapter 6)

**Extract 6.1. (H3 V61 D23 Da. 7/1/2012. Cl. Haem. ) (Pt: aged 50; her daughter: aged 25)**

- 97 Dr1: =ya ni ma bta khdhi sh ala u l il bta <sup>3</sup>ghuda?  
98 Pt: la ma a khudh kul ala u l, habitli iltiha b.  
99 Dr1: ma hwwa hwwa bta ><sup>3</sup>ghuda da ma bi milsh iltiha b wala,  
100 a ga <ka n bta khdi minu haba t, =  
101 Pt: = iggi r i h.  
102 Dr1: → iggi r? illi hi a ka n khamisa w ishri n micru gram illi bitakhadhiha?  
103 Pt: → i wah.  
104 F.CH: →i wah i wah.

- 97 Dr1: =you don't constantly take the drug for your glands?  
98 Pt: No I don't take it constantly; it gave me a burning sensation.  
99 Dr1: The one which is for >glands doesn't cause any burning nor,  
100 anything else <did you used to take a tablet? =  
101 Pt: =a small one yes.  
102 Dr1:→ Small? Twenty-five milligrams?  
103 Pt: → Yeah.  
104 F.CH: →Yeah yeah.

**Extract 6.2. (H3 V2 D2 Da. 10/12/2011. Cl. Radio-th. ) (Pt: aged 35; her husband: aged 49)**

- 26 Dr1: → tishtiki n min shai ?  
27 M.CH:→ >laa<sup>↑</sup> nisi na <sup>3</sup>mu id ya duktu r liduktu r <sup>3</sup>aw i a ad-damawi a<  
28 Dr1: li h kida ?  
29 M.CH: ° erm° nisi na wa fa t ali na <sup>3</sup>maw id.

- 26 Dr1: → Do you have any complaints?  
27 M. CH: →>No<sup>↑</sup> we missed the appointment with the vascular surgeon <  
28 Dr1: Why?  
29 M.CH: erm we forgot and we missed the appointment.

**Extract 6.3. (H3 V12 D8 Da. 18/12/2011. Cl. Sur. Onc.) (Pt: aged 45; her sister: aged 30)**

- 55 Dr1. → bitakhadi li l q <sup>3</sup>sukar bintizam?  
56 Pt. → i\_wah.

57 F. CH → i\_wah (.) i\_wah.

---

55 Dr1. → Do you take drugs for diabetes regularly?

56 Pt. → Yeah.

57 F.CH → Yeah (.) yeah.

**Extract 6.4. (H3 V8 D5 Da. 13/12/2011. Cl. Sur. Onc.) (Pt: aged 32; her husband: aged 40)**

15 Dr1: → mata sawi ti ashi a at-tilfizyu ni a?

16 Pt: → gabl usbu i n.

17 M.CH: → gabl usbu i n.

18 Dr1: → gabl usbu i n?

19 Pt: → i\_wah.

---

15 Dr1: → When did you have the ultrasound?

16 Pt: → Two weeks ago.

17 M.CH: → Two weeks ago.

18 Dr1: → Two weeks ago?

19 Pt: → Yeah.

**Extract 6.5. (H3 V8 D13 Da. 18/12/2011. Cl. Chemo) (Pt: aged 70; her daughter (40) and son (37))**

40 Dr1. → bas ti asi ba alam fi dhi ra k <sup>3</sup>ilaysar?

41 Pt. → i wah.

42 F.ch. → wa yida nha kama n.

---

40 Dr1. → Do you feel pain in your left arm?

41 Pt. → Yeah.

42 F.ch. → And in both her hands as well.

**Extract 6.6. (H3 V8 D13 Da. 18/12/2011. Cl. Chemo) (Pt: aged 70; her daughter (40) and son (37))**

55 Dr1: → mashya takhdi abayyat min

56 → <sup>3</sup>birsham alli di ka ki ?

57 Pt: → abati n=

58 F.ch: → = abah fi <sup>3</sup>ywam wa dah fi <sup>3</sup>liyal.

59 Pt. → abah fi <sup>3</sup>ywam wa dah fi <sup>3</sup>liyal.

---

- 55 D1: Are you still taking the tablets  
 56 → that we've prescribed?  
 57 Pt: → Two tablets =  
 58 F.ch → =one during the day and one at night.  
 59 Pt. One during the day and one at night.

**Extract 6.6. (H3 V8 D13 Da. 18/12/2011. Cl. Chemo) (Pt: aged 70; her daughter (40) and son (37))**

- 55 Dr1: mashya takhdi abayyat min  
 56 → <sup>3</sup>birsham alli di ka ki ?  
 57 Pt: → abati n=  
 58 F.ch: → = abah fi <sup>3</sup>ywam wa dah fi <sup>3</sup>liyal.  
 59 Pt. abah fi <sup>3</sup>ywam wa dah fi <sup>3</sup>liyal.

- 55 D1: Are you still taking the tablets  
 56 → that we've prescribed?  
 57 Pt: → Two tablets =  
 58 F.ch → =one during the day and one at night.  
 59 Pt. One during the day and one at night.

**Extract 6.7. H3 V 63 D 23 Da.7/1/2012 Cl. Chemo-th. (Pt: 50; her husband aged 60)**

- 36 Dr1: (A) → li hma<sup>↑</sup> li h ma a a<sup>↑</sup> ki s hina?  
 37 Pt: (B) → ° gas ara ma fi .°  
 38 M.CH: (C) → a u hum- a uha kyas filmustashfa wa  
 39 jinahum wa aha ga lu ma fi a d khala at <sup>↑</sup>  
 40 Pt: (D) → they are khala at.  
 41 M.CH: (E) → ma a u na ki a s laha.

- 36 Dr1: (A) → Why didn't <sup>↑</sup> why didn't you have <sup>↑</sup> a bag here?  
 37 Pt: (B) → There was no ° catheterisation. °  
 38 M.CH: (C) → They gave them –they gave her bags in the hospital and we  
 39 went again and they said there were none left, they were finished<sup>↑</sup>  
 40 Pt: (D) → They were finished.  
 41 M.CH: (E) → They didn't give us any bags.

**Extract 6.8. H3 V61 D23 Da. 7/1/2012. Cl. Haem. (Pt: aged 50; her daughter: aged 25)**

- 97 Dr1: =ya ni ma bta khdhi sh ala u l il bta <sup>3</sup>ghuda?

98 Pt: la ma a khudh kul ala u l, habitli iltiha b.  
 99 Dr1: ma hwwa hwwa bta ><sup>3</sup>ghuda da ma bi milsh iltiha b wala,  
 100 a ga <ka n bta khdi minu haba t, =  
 101 Pt: = iggi r i h.  
 102 Dr1: → iggi r illi hi a ka n khamisa w ishri n micru gram illi bitakhadhiha?  
 103 Pt: → iwah.  
 104 F.CH: → iwah iwah.  
 105 Dr1: <khala khaliki mashya ala ↑ tala tah.>  
 106 <ayi b at-ta li l <sup>3</sup>hamdu ↑ l-lah kuwais bita ik.>

-----  
 97 Dr1: =you don't constantly take the drug for your glands?  
 98 Pt: No, I don't take it constantly as it causes a burning sensation.  
 99 Dr1: The one which is is for >glands doesn't cause any burning,  
 100 nothing <you used to take a tablet, =  
 101 Pt: =a small one yes.  
 102 Dr1: → Small—which was the twenty five milligram tablet?  
 103 Pt: → Yeah.  
 104 F.CH: → Yeah yeah.  
 105 D1. Okay continue taking three tablets.  
 106 D1. <Okay your test thank God ↑ is good.>

**Extract 6.9. H1 V6 D3 Da. 06/12/2011. Cl. Chemo-th. (Pt: aged 36, her husband: aged 41)**

32 Dr1: <mi n sa wa lik <sup>3</sup>ashi a? >  
 33 Pt: a ad-duktu r ° ka n duktu r . ° =  
 34 Dr2: → huwa duktu r illi sa wa lik <sup>3</sup>ashi a?  
 35 Pt: → i\_wah.  
 36 M.CH: → i\_wah.  
 37 Dr1: tishtiki n min shai ?

-----  
 32 Dr1: <Who did the ultrasound for you?  
 33 Pt: Erm a male doctor ° it was a male doctor. ° =  
 34 Dr2: → It was a male doctor who did the ultrasound?  
 35 Pt: → Yeah.  
 36 M.CH: → Yeah.  
 37 Dr1: Do you have any complaints?

**Extract 6.10. H3 V 90 D 31 Da. 25/01/2012 Cl. Chemo-th. (P: aged 62, her daughter aged: 23)**

55 Dr1: → a h lamma t ali inti <sup>3</sup>a ab fi n illi yitshadad ?  
 56 Pt: → hina .  
 57 F.CH: → hina .  
 58 Dr1: → mumkin turu ri ala alsareer afhasik?



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- 55 Dr1:→ When you pray, where is the nerve that is tight?  
56 Pt: → Here.  
57 F.CH → Here  
58 Dr1: Can you get onto the bed so I can examine you?

**Extract 6.11 (continued from extract 6.10 above) H3 V 90 D 31 Da.25/01/2012 Cl.**

**Chemo-th. (P: aged 62, accompanied by 23-year-old daughter)**

- 137 Pt:                   <sup>3</sup> a la tigu l mustagira shwai a?  
138 Dr1:                 a ::h,  
139 Pt:                 [<sup>3</sup> amdu lila h.  
140 Dr1:         → [ inti bti gi mnilmadi na walla mni n? =  
141 Pt:         → = i h, a ji manilmadi na.  
142 F.CH:       → manilmadi fffffa.  
143 Pt:         → ili indak<sup>3</sup> i n kam sa a ? heh heh  
144 F.CH:       → min<sup>3</sup>madi na.

-----

- 137 Pt:                 You said that the situation is a little bit stable?  
138 Dr1:                Ye::s ,  
139 Pt:                 [Thanks Allah.  
140 Dr1:         → [Do you come from Madina or where? =  
141 Pt:         → =I come from WHERE? Yeah, I come from Madina.  
142 F.CH:       → from Madin(ffff)a.  
143 Pt:         → For how long have I been with you now for how many years? heh heh  
144 F. CH:       → From Madina.

**Extract 6.12. H3 V 13 D8 Da.18/12/2011. Cl.Chemo. (P: aged 70; chaperones:  
her son: aged 37, her daughter: aged 40**

- 15 Dr1:               fi iyi aa a ma shakil? iyi aa shakwa ? ti abi tu uliha li ? =  
16 Pt:                =<sup>3</sup> amd lil-lah↓, ila indi :: ya ni khumu l ↑ madri huu min  
17                   <sup>3</sup>kima wi ? (.) ma a d gidrat agu m (.) madri wu min SHAI ?  
18 Dr1:→           ya ni ma ti dari sh tu wimi min lam rukabik? wal-la  
19         →           ti dari sh tu wimi min i h?  
20 Pt: →            i wa  
21 F.CH: →         JISMAHA ↑ kullah↑ ta ba n=  
22 Pt:         → =jismi ↑ kullah↑ ta ba n.

- 15 Dr1:                Are there any problems? Any complaints you would like to tell me about? =  
16 Pt:                =Thank God↓, I am:: lazy ↑ I don't know is it due to the  
17                    chemo? (.) I couldn't stand (.) I don't know is it caused by soMETHING?  
18 Dr1: →            You couldn't stand from the pain in your knees? Or  
19         →            you couldn't stand because of what?  
20 Pt:         →        Yeah

- 21 F.CH: → HER BODY↑ as a whole ↑ is ill=  
 22 Pt: → =My body↑ as a whole↑ is ill.

**Extract 6.13. H3 V45 D17 Da. 31/12/2011. Cl. Chemo-th. (Pt: aged 69, her daughter: aged 35)**

- 108 Dr1: → la kin law ga lik↑ tru i mariti n talata  
 109 filyu m?  
 110 Pt: → i ::wa.  
 111 F.CH: → > a ian akthar. <  
 112 D1: mai a kha li ? walla  
 113 P: mai a.

-----

- 108 D1: → But if you have it↑ do you go to the bathroom two or three times  
 109 a day?  
 110 P: → Ye:ah.  
 111 F.CH: → >Sometimes more. <  
 112 D1: Is it liquid ? Or  
 113 P: Liquid.

**Extract 6.14. H3 V 90 D 31 Da.25/01/2012 Cl. Chemo-th. (Pt: 62, her daughter: aged 35 )**

- 42 Dr1: = at at-ta ali l ai ba<sup>3</sup> amdu lila h ↓ kwai (hhh)sa. =  
 43 Pt: <sup>3</sup> amdu lila h ↓ bas↑ ana ma a i ala m fi ah - fi a mi ,  
 44 D1: → filmafa il walla filrigl ka man? =  
 45 Pt: → kulaha :: ha dhi <sup>3</sup>mafa il min ind taba an ar-rukba ha dhi ↑ =  
 46 → > matthlan la ma aba ana kida a ali ,<=  
 47 F.CH: → =ma tigdar tirka =  
 49 Pt: → =ma agdar arka , a is<sup>3</sup> a ab ma i mitshadid (hhh).

- 42 Dr1: =The tests are good, thanks Allah ↓ goo(hhh)d. =  
 43 Pt: Thanks Allah ↓ but ↑ I have pains in my back- in my bones,  
 44 Dr1: → In joints or in feet as well?=  
 45 Pt: → = in a::ll of the joints from of course this knee ↑ =  
 46 Pt: >For example, if I want to pray,<=  
 48 F.CH: → =She cannot kneel.=  
 52 Pt: → =I cannot kneel, I feel that the nerve is tense (hhh).

**Extract 6.15. H3 V 14 D 9 Da.19/12/2011 Cl. Chemo-th. (Pt: aged 70; her son, aged 38)**

- 64 Dr1: tishtiki n min shai ?  
 65 Pt. iwah iimsa k

66 Dr1: → bitakhadi ilag Iliimsa k?  
 67 Pt. → khud ilag =  
 72 M.CH. → =bidu n i faiydah↓=  
 73 Pt. = ilag bidu n i faiydah =  
 74 M.CH. =bass yawm sau lana (.) aaa<sup>3</sup> shi ah<sup>3</sup>maq a i ah,↓  
 75 (0.1) ma sha al-la h ta asanat ya ani  
 76 Dr1. IWAH,

-----  
 64 Dr.1. Do you have any complaints?  
 65 Pt. Yeah I have constipation  
 66 Dr1: → Do you take medicine for the constipation?  
 67 Pt. → I take medicine=  
 72 M.CH. → =>it's no use<.=  
 73 Pt. → =I take medicine but it's of no use.=  
 74 M. CH. =But the day they did (.) aaa the CT scan,↓  
 75 (0.1) thank God she is getting a little bit better.  
 76 Dr1. OKAY,

**Extract 6.16. H3 V 85 D 29 Da.18/1/2012 Cl. Chemo-th. (Pt: 43; her sister: aged 35)**

319 Dr1. ila g ki ma wi ba wlik wighit nazari ana  
 320 ISH-SHAKHi ah innu a - ib<sup>3</sup>badi l, da ↑ nilga li ba d (0.1)  
 321 ma tafshal kulila illa wasa il ila<sup>3</sup> ilmi a<sup>3</sup>ma ru fa ya ni .  
 322 hhh (0.1) ana afa al kida ya ni ma fa alshi ininti  
 323 tilga i li - ib<sup>3</sup>badi l<sup>3</sup> AWI(h)L (.) wa ba di n lamma  
 324 yifshal nilga lil lilki ma wi tuku n l<sup>3</sup> a la it akharit  
 325 (A)→ fahmani?  
 326 Pt. (B)→ i wah.  
 327 Dr1. (C)→ wighit nazari ana ink la tibda i ila g ki ma wi  
 328 min<sup>3</sup>yaum  
 329 F.CH. (D)→ la tibda i ila g ki ma wi  
 330 Pt. (E) → tai b.

-----  
 319 Dr.1 The in my personal opinion chemotherapy is better↑  
 320 than this alternative medicine, we sometimes resort to after  
 321 (0.1) the failure of all known scientist methods.  
 322 hhh (0.1) I don't wish you to resort to  
 323 alternative medicine FIRST (.) and then when it fails  
 324 we resort to chemo as in this case it is too late  
 325 (A) → Do you understand me?  
 326 Pt. (B) → Yeah.  
 327 Dr1. (C) → From my personal point of view you have to start  
 328 chemotherapy from today  
 329 F.CH. (D)→ You have to start chemotherapy  
 330 Pt. (E)→ Okay.

**Extract 6.17. H3 V 63 D 23 Da.7/1/2012 Cl. Chemo-th. (P: 50 year old patient accompanied by 60 year old husband)**

87 Dr1: bu i ya sitti dilwa ti <sup>3</sup> ila g illi a ritik atakhdi dawa t  
 88 MALU L (.) ha h ? =  
 89 Pt. = i wa.  
 90 Dr1: → biyita khid marra kuli talat asabi ,=  
 91 M. CH. → =takh i marra .  
 92 Pt. → i wa.  
 93 Dr1. wa da wa da yata allab<sup>↑</sup> ba ila ila i tya a t<sup>↓</sup> ha ?=  
 94 Dr1. <sup>3</sup> i tya a t di <sup>↑</sup> ini inti lazim tishrabi  
 95 → mayya, wa sawa i l KITI R.  
 96 M. CH: → inti lazim tishrabi mayya, wa sawa i l KITI R=  
 97 Pt: → = ai wa.  
 98 Dr1: MAYYA (.) WA SAWA (.) I l KITI R. ha h?  
 98 Pt: ai wa.

-----  
 87 Dr1: Look madam, now, the medication that you're going to take  
 88 is A DRUG (.) huh? =  
 89 Pt: =yeah.  
 90 Dr1: → It is to be taken once every three weeks,=  
 91 M.CH: → =you must take it once.  
 92 Pt: → Yeah.  
 93 Dr1: And this requires <sup>↑</sup> some pre pre prerequisites <sup>↓</sup> okay? =  
 94 Dr1: These<sup>↑</sup> prerequisites are that you must drink  
 95 → Plenty of <sup>↓</sup> water and liquids  
 96 M.CH: → You have to drink PLENTY of water and liquids=  
 97 Pt: → =yeah.  
 98 Dr1: PLENTY<sup>↓</sup> WATER (.) AND LIQUIDS. huh?  
 99 Pt: =yeah.

**Transcripts in Chapter 7**

**Extract 7.1. H3 V12 D12 Da. 24/12/2011. Cl. Chemo-th. (Pt: aged 39; her husband: aged 46)**

14 Dr1 → tishtiki n min shai ?  
 15 Pt: → i wa fi(hhh) aLAM=  
 16 M. Ch: → = i wa fi alam  
 -----  
 14 Dr1: → Do you have any complaints?  
 15 P: → Yeah ther (hhh) e is pAIN=  
 16 M.CH: → =yeah there is pain

**Extract 7.2. H3 V 23 D 7 Da. 7/1/2012 Cl. Chemo. (Pt: aged 41, her mother, aged 60)**

- 1 F.CH. <ta ba nah nu rah. >  
2 Dr. o::↓oh  
3 Dr. ta - ba nah↓ nu r[ah?  
4 F.CH. [wal-la::h ma tu::dhu q sh↑ ai =  
5 Dr. =↑ ha ash mushkilah?  
6 (0.1)  
7 F. CH. ar[sh (.) wa kuhah ma::rah baD-DAQI QAH  
8 Dr. arSH wa kuHAH?  
9 F. CH. iywah↓ iywah↓  
10 Dr. wa aRSH ba ad al-la akil wala bidu n al-LKIL wala ,  
11 F. CH. ma TA KU::L  
12 Dr. (.) ma a KU::L ?  
13 F. CH. ma :: TA KU::L ,  
14 Dr. bass arish.  
15 F. CH. [ma ↑takul  
16 Dr. [inti amaliti ashi ah qalb ma uh  
17 (0.1)  
18 Dr: [sawatu ashi ah↑  
19 F.CH. [tishki tishki minaha=  
20 Pt: =°ma sawa na ↓°  
21 Dr. ↑huh ma sawatu ?  
22 F.CH. iywa::h  
23 Dr. > akhar tanu im ma sawa tu ashi ah- aq<sup>3</sup>ra s<  
24 F.CH. la .  
25 Dr. wa ba di n ish fi ah ta ni ku-h(h)ah=  
26 F. CH. = adrahah hina  
27 Dr. fi h balgham wala shi ↑  
28 F. CH. alam alam.  
29 Dr. alam fia ↑ - dar  
30 ma fi balgham wala shi ma a kuhah  
31 F.CH. °mm°  
32 Dr. bass kuhah↑  
33 F. CH. iywah↓  
34 Dr. mhmm  
35 fi iyy sukhu nah wala shi ? =  
36 F. CH. =wa ba di n arashat liylat<sup>3</sup> awal- aaa  
37 arashat dam↓(.) liylat<sup>3</sup> awal  
38 Dr. arashat dam  
39 F.CH. liylat<sup>3</sup> awa::l  
40 Dr. mhmm  
41 F. CH. arashat dam  
42 Dr. kum mita mita  
43 F. CH. liylat<sup>3</sup> awa::l=

- 44 Pt. =bass arashat dam marah wa adah. =  
 45 F.CH. =wa adah. wa adah.  
 46 Dr. hina akhat tanwi m wala fi <sup>3</sup>bai t?  
 47 F.CH. [makhadha::t tanwi m fi <sup>3</sup>bai ::t.  
 48 Pt. [ARRTa at fi <sup>3</sup>bai ::t  
 49 F. CH. fi <sup>3</sup>bai ::t.  
 50 Dr. fi <sup>3</sup>bai t↓ fi <sup>3</sup>bai t.  
 ((Ten lines cut))  
 61 Dr. I also need an admission paper. ((Doctor is speaking in English))  
 62 N. Admission paper?  
 63 Dr. Because Nurah is here for admission now.  
 64 N. mm.  
 65 (0.2) ((the doctor is writing))  
 66 Pt. ba anti yuj(h)a ni ↓ ba ANTI .  
 67 ((doctor is still writing))  
 68 F. CH. tishiki min ba naha  
 69 ((the doctor is reading Nurah's file))  
 70 (0.27)  
 71 Dr. min <sup>3</sup>ra HA (.) min <sup>3</sup>ma RA ↓ anti a raf=  
 72 =mushkilah hina fi <sup>3</sup>ra HA,=  
 73 F. CH. =wa ba anaha ?=  
 74 Dr. wa fi ba an kama n, [haza min <sup>3</sup>al <sup>3</sup>mara kama n.  
 75 F. CH. [iwah.  
 76 Dr. insha l-la h↑ dahi n aktub tanwi m insha l-la h [( )

- 1 F. CH. <Nurah↓ is ↑sick>  
 2 Dr. o::↓oh  
 3 Dr. Are- you sick↓ Noura?  
 4 F. CH. I swear to Go::d that she hasn't eaten any↑thing=  
 5 Dr. =↑ Okay what's the problem?  
 6 (0.1)  
 7 F. CH. Vomit[ing (.) and a seve::re cough every MINUTE.  
 8 Dr. VomitING and a coUGH?  
 9 F. CH. yeah↓ yeah↓  
 10 Dr. And voMITING after food or without FOOD or,  
 11 F. CH. she didn't EA::T  
 12 Dr. (.) she didn't n't EA::T?  
 13 F. CH. She didn't EA::T,  
 14 Dr. Only vomiting,  
 15 F.CH: [she didn't ↑ eat  
 16 Dr. Have you (sing.) had a heart x-ray?  
 17 (0.1)  
 18 Dr: [have you (pl.) had an x-ray?  
 19 F.CH. [she is complaining she is complaining =  
 20 Pt. =°we haven't ↓°  
 21 Dr. Huh? You (sing.) haven't?

22 F. CH. Yea::h.  
 23 Dr. >On the last admission you didn't have a heart x-ray<  
 24 F.CH. No.  
 25 Dr. And is there anything else cou(h)gh =  
 26 F. CH. =Her chest here.  
 27 Dr. Is there any sputum or anything?  
 28 F. CH. Pain pain.  
 29 Dr. Pain in ↑ the chest (.)  
 30 No sputum nor anything else with the cough?  
 31 F.CH. °mm°  
 32 Dr. Only a cough?  
 33 F. CH. Yeah.  
 34 Dr. Mhmm  
 35 Is there any fever or anything =  
 36 F. CH. =And she vomited last- night -aaa  
 37 She had blood when vomiting↓ (.) the day before yesterday  
 38 Dr. She had blood when vomiting  
 39 F. CH. The day befo::re yesterday  
 40 Dr. Mhmm  
 41 F.CH. She had blood when vomiting  
 42 Dr. How many when when?  
 43 F. CH. The day befo::re yesterday=  
 44 Pt. =I only vomited blood once.=  
 45 F.CH. =Once. Once.  
 46 Dr: Were you admitted here or did you stay at home?  
 47 F. CH. [she wasn't admitted she was only at home↓  
 48 Pt: [I RELAXED at ho:me  
 49 F. CH. at ho::me.  
 50 Dr: at ho::me at ho::me

((ten lines cut))

61 Dr. I also need an admission paper. ((Doctor is speaking in English))  
 62 N. Admission paper?  
 63 Dr. Because Nurah is here for admission now.  
 64 N. Mm.  
 65 (0.2) ((the doctor is writing))  
 66 Pt. My stomach I have ↓ pa(h)in my stomach.  
 67 ((doctor is still writing))  
 68 F. CH. She is complaining about her stomach  
 69 ((the doctor is reading Nurah's file))  
 70 (0.27)  
 71 Dr. The luNG (.) From the disEASE↓ you know=  
 72 =the problem here is in the luNG,=  
 73 F. CH. =and her stomach?=  
 74 Dr. =and the stomach as well, [this is from the disease as well.  
 75 F. CH. [yeah.  
 76 Dr. God willing now I will write an admission in [God's willing ( )

**Extract 7.3. H3 V. 14 D. 14 Da.25/12/2011 Cl. Haem. (Pt: aged 65, her daughter, aged 29)**

- 7 ((the researcher put the audio- recording on the doctor's office))  
8 ((door is closed))  
9 (0.3)  
10 ((the second doctor is opening the patient's file))  
11 ((the consultant is talking to the second doctor))  
12 ((the second doctor is dictating the consultant the patient's file number))  
13 Dr2. wahid afar thalathah thalathah↓  
14 Dr1. aaywah,  
15 (0.3)  
16 Dr2. arba ah sitah thalatah kha::masah↓  
17 ((the consultant is typing into the patient's file on the computer))  
18 Dr1. thalatah khamasah↓  
19 (0.4)  
20 Dr1. ( )  
21 Dr2. a h,(0.2) kam <sup>3</sup>a (.) takhudi kam abah↓ arba aba t↓  
22 F. CH. iywah↓  
23 (0.4)  
24 Dr2: nisyu ma adaha <sup>3</sup>ma ↓ giti sh li ah  
25 <sup>3</sup>marah <sup>3</sup>li fa tit ma dik?  
26 F.CH. ka nat misa ::frah↓  
27 Dr1. → akhudi <sup>3</sup> la q wala la ah  
28 (0.1)  
29 F. CH. iah batakhudu bas imba ri t abat shwaiyyah↓  
30 Dr1. iyyah al-li ta abak?  
31 F. CH. ma adri shakluhu::↓ ( 0.2) y[a a↑ni  
32 Dr1. [ a sah bi ayyah↓  
33 F. CH. ka nat min a - a wa ahiyat↓ asa h wa, (0. 2)  
34 wa asa h shi-yyi ya ani fi shiyyi↓ ( )  
35 fi na[fsaha h  
36 Dr1. [du kha ya ani w[ala a gah  
37 F. CH. [iyi::wah (0.1) du kha  
38 Dr1. ( ) ya mohammad↑ (D1 is calling D2)  
39 (0.5) ( the second resident doctor is looking at the patient's file)  
40 Dr2. huwa maktu b min RBS normal last time but:[a was this in English?  
41 Dr1. [°normal one°↓  
42 Dr2. But anaemic she was↑ anaemic she was before anaemic↓  
43 (0. 4)  
44 Dr1. ( )  
45 Dr2. taiyyb <sup>3</sup>hi mu - <sup>3</sup> hi mu qlubi kam↑(0.1) ten point seven  
46 Dr2. indik agh ya umi wala SUKAR  
47 F. CH. ° indaha as-suk[ar°↓  
48 Pt. [ indindi as-sukar wa rasiyy↓



49 Dr2. [takhud aliyaha bu b↑]  
 50 F. CH. °iywah°↓  
 51 Dr1. ai b tita ba as-skar ma a ad-duktu r[ ha↑  
 52 Pt. [ andi sukar wa andi  
 53 abah fi al-liyyal wa abah fi a - abah]  
 54 Dr2. intu min fiyyan↓ intu min fiyyan↓  
 55 F. CH. °min ʔrawabi ↓°

-----  
 7 ((the researcher put the audio- recording on the doctor's office))  
 8 ((door is closed))  
 9 (0.3)  
 10 ((the second doctor is opening the patient's file))  
 11 ((the consultant is talking to the second doctor))  
 12 ((the second doctor is dictating the consultant the patient's file number))  
 13 Dr2. One zero three three↓ ((D2 is dictating D1 the patient's file))  
 14 Dr1. Yeah,  
 15 (0.3)  
 16 Dr2. Four six three fi::ve↓  
 17 ((the consultant is typing the patient's file into the computer))  
 18 Dr1. Three five ↓  
 19 (0.4)  
 20 Dr1. ( )  
 21 Dr2. erm (0.2) how erm (.) How many tablets do you take↓ four tablets?  
 22 F. CH. Yeah.  
 23 (0.4)  
 24 Dr1. They forgot her appointment↓why didn't  
 25 you come last time your appointment?  
 26 F. CH. she had been a wa::y.  
 27 Dr1. You are taking the medicine or not?  
 28 (0.1)  
 29 F. CH. Yes she is taking it but yesterday she was a little bit sick.  
 30 Dr1. What makes you sick?  
 31 F. CH. I don't know it see::ms↓ (0.2) I [mea↑n  
 32 Dr1. [what do you feel ?  
 33 F. CH. She woke up↓ in the morning she felt and (0.2)  
 34 she felt with some-thing I mean there is something  
 35 in her[self  
 36 Dr1. [dizziness I mean o[r something like that?  
 37 F. CH. [ye::ah (0.1) dizziness  
 38 Dr1. ( ) Oh mohammad↑  
 39 (0.5) ( the second resident doctor is looking at the patient's file)  
 40 Dr2. It's written from RBs normal last time but::[a  
 41 Dr1. [°normal one°↓  
 42 Dr2. But anaemic she was↑ anaemic she was before anaemic↓  
 43 (0.4)

- 44 Dr1. ( )  
 45 Dr2. Ok much haemo- haemoglobin↑ (0.1) ten point seven ( )  
 46 Dr2. Do you have my mum's blood pressure or DIABETES?  
 47 F. CH. °she has diabetie[s°↓  
 48 Pt. [I have diabetes and headache↓]  
 49 Dr2. [Does she take tablets for that?]  
 50 F. CH. °yeah°↓  
 51 Dr1. Let her check the diabetes with the doctor [ok?  
 52 Pt. [I have diabetes and  
 53 I have one tablet in the evening and a tablet in the morning]  
 54 Dr2. Where are you from ↓ where are you from↓  
 55 F. CH. °from Al-Rawabi ↓°

**Extract (7.2.1) (continued from Extract 7.2).**

- 5 Dr. =↑ okay what's the problem?  
 6 (0.1)  
 7 F. CH. Vomit[ing (.) and a seve::re cough every MINUTE.  
 8 Dr. → VomitING and a coUGH?  
 9 F. CH. → Yeah↓ yeah.  
 10 Dr. And voMITING after food or without FOOD or,

**Extract (7.2.2) (continued from Extract 7.2).**

- 27 Dr. Is there any sputum or anything?  
 28 F. CH. Pain pain.  
 29 Dr. Pain in ↑ the chest (.)  
 30 No sputum nor anything else with the cough?  
 31 F.CH. °mm°  
 32 Dr. → Only a cough?  
 33 F. CH. → Yeah.  
 34 Dr. Mhmm  
 35 Dr. Is there any fever or anything? =

**Extract (7.3.1) (continued from Extract 7.3)**

- 16 Dr2. Four six three fi::ve↓  
 17 ((the consultant is typing the patient's file in the computer))  
 18 Dr1. Three five ↓  
 19 (0.4)  
 20 Dr1. ( )  
 21 Dr2. → Erm (0.2) how erm (.) how many tablet do you take↓ four tablets?  
 22 F. CH. → Yeah.  
 23 (0.4)  
 24 Dr1. They forgot her appointment↓why didn't

**Extract (7.3.2) (continued from Extract 7.3)**

- 46 Dr2. Do you have my mum's blood pressure or DIABETES?  
47 F. CH. °she has diabetic[s°.  
48 Pt. [I have diabetes and headache.]  
49 Dr2. → [Does she take tablets for that?]  
50 F. CH. → °yeah°.  
51 Dr1. Let her check the diabetes with the doctor [ok?  
52 Pt. [I have diabetes and  
53 I have one tablet in the evening and a tablet in the morning.]  
54 Dr2. Where are you from ↓ where are you from?

**Extract 7.2.3 (continued from Extract 7.2) Noura's case**

- 10 Dr. → And voMITING after food or without FOOD or,  
11 F. CH. → She doesn't EA::T  
12 Dr. → (.) she does n't EA::T?  
13 F. CH. → She doe::sn't EA::T,  
14 Dr. Only vomiting,  
15 F.CH: [she doesn't ↑ eat  
16 Dr. [Have you (sing.) had a heart x-ray  
17 (0.1)

**Extract 7.2.4 (continued from Extract 7.2) Noura's case**

- 1 F. CH. <Nurah↓ is ↑sick>  
2 Dr. o::↓oh  
3 Dr. → Are- you sick↓ Nour[ah?  
4 F. CH. → [I swear to Go::d that she hasn't eaten any↑thing=  
5 Dr. → =↑ okay what's the problem?  
6 (0.1)

**Extract 7.2.5 (continued from Extract 7.2) Noura's case**

- 1 F. CH. <Noura↓ is ↑sick>  
2 Dr. o::↓oh  
3 Dr. → Are- you sick↓Noura[ah?  
4 F. CH. → [I swear by Go::d that she hasn't eaten any↑thing=  
5 Dr. → =↑ okay what's the problem?  
6 (0.1)  
7 F. CH. → Vomit[ing (.) and a seve::re cough every MINUTE  
8 Dr. VomitING and a coUGH?  
9 F. CH. Yeah↓ yeah↓  
10 Dr. → And voMITING after the food or without FOOD or,  
11 F. CH. → She doesn't EA::T  
12 Dr. (.) she does n't EA::T?  
13 F. CH. She doe::sn't EA::T,  
14 Dr. Only vomiting,  
15 F.CH: [she doesn't ↑ eat

16 Dr. [Have you (sing.) had a heart x-ray  
17 (0.1)  
18 Dr: [have you (pl.) had x-ray↑  
19 F.CH. [she is complaining she is complaining =  
20 Pt. =°we haven't ↓°  
21 Dr. Huh? you (sing.) haven't?  
22 F. CH. Yea::h  
23 Dr. >On the last admission you didn't have a heart x-ray<  
24 F.CH. No.  
25 Dr. → And is there anything else cou(h)gh =  
26 F. CH. → =her chest here  
27 Dr. Is there any sputum or anything↑  
28 F. CH. Pain pain.  
29 Dr. Pain in ↑ the chest (.)  
30 No sputum nor anything else with the cough  
31 F.CH. °mm°  
32 Dr. Only a cough↑  
33 F. CH. Yeah↓  
34 Dr. Mhmm  
35 → Is there any fever or anything ↑ =  
36 F. CH. → =and she vomited last- night -aaa  
37 She had a blood vomiting↓ (.) the day before yesterday  
38 Dr. She had a blood vomiting

**Extract (7.3.3) (continued from Extract 7.3) Fatma's case)**

24 Dr1. They forgot her appointment↓why didn't  
25 You come last time your appointment?  
26 F. CH. She had been a wa::y↓  
27 Dr1. → You are taking the medicine or not↑  
28 (0.1)  
29 F. CH. → Yes she is taking but yesterday she was a little bit sick↓  
30 Dr1. What makes you sick?

**Extract 7.2.6 (continued from Extract 7.2) Noura's case**

41 F.CH. She had a blood vomiting  
42 Dr. How many when when?  
43 F. CH. The day befo::re yesterday=  
44 Pt. =I only vomited blood once.=  
45 F.CH. =once. once.  
46 Dr: → Have you admitted here or you stayed at home?  
47 F. CH. → [she hasn't admitted she was only at home.  
48 Pt: → [I RELAXED at ho:me.  
49 F. CH. At ho::me.  
50 Dr. At ho::me, at ho::me.

**Extract (7.3.4) (continued from Extract 7.3) Fatma's case**

- 45 Dr2. Ok much haemo- haemoglobin↑ (0.1) ten point seven ( )  
46 Dr2. Do you have my mum's blood pressure or DIABETES?  
47 F. CH. → °she has diabetic[s°↓  
48 Pt. → [I have diabetes and headache↓]  
49 Dr2. → [Does she take tablets for that↑]  
50 F. CH. °yeah°↓  
51 Dr1. → Let her check the diabetes with the doctor [ok?  
52 Pt. → [I have diabetes and  
53 → I have one tablet in the evening and a tablet in the morning]  
54 Dr2. Where are you from ? where are you from?

**Extract (7.3.5) (continued from Extract 7.3) Fatma's case**

- 24 Dr1. They forgot her appointment↓why didn't  
25 You come last time for your appointment?  
26 F. CH. She had been a wa::y↓  
27 Dr1. You are taking the medicine or not?  
28 (0.1)  
29 F. CH. Yes she is taking but yesterday she was a little bit sick.  
30 Dr1. What makes you sick?  
31 F. CH. → I don't know it see::ms↓ (0.2) I [mea↑n  
32 Dr1. [what do you feel?  
33 F. CH. → She woke up↓ in the morning she felt and (0.2)  
34 She felt some-thing I mean there is something  
35 in her[self  
36 Dr1. [is it dizziness o[r something like that?  
37 F. CH. → [ye::ah (0.1) dizziness.  
38 Dr1. ( ) oh mohammad↑

**Extract 7.2.7 (continued from Extract 7.2) Noura's case**

- 61 Dr. I need an admission paper also.  
62 N. Admission paper?  
63 Dr. Because Noura is for admission now.  
64 N. Mm.  
65 (0.2) ((the doctor is writing))  
66 Pt. My stomach I have ↓ pa(h)in my stomach.  
67 ((doctor is still writing))  
68 F. CH. She is complaining of her stomach  
69 ((the doctor is reading Noura's file))  
70 (0.27)  
71 Dr. → The luNG (.) from the disEASE↓ you know=  
72 → =the problem here is in the luNG,=  
73 F. CH. → =and her stomach?=  
74

- 74 Dr. → =and the stomach as well, [this is from the disease as well.  
75 F. CH.--> [yeah.  
76 Dr. God willing now I will write an admission in [God willing ( )