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Anna Kuzio https://orcid.org/0000-0002-6914-9060
University of Zielona Góra
e-mail: a.kuzio@in.uz.zgora.pl

Historical and Cultural Aspects of Politeness in Constructing Narrative Coherence in Patient and Doctor Communication

Historyczno-kulturowe aspekty grzeczności i ich rola w konstruowaniu spójności narracyjnej w komunikacji między pacjentem a lekarzem

Abstract

This paper aims at showing a study on how doctors as well as patients try to negotiate in the process of communication with special attention to the aspect of narrative in the medical interactions and the concept of politeness that is culturally and historically shaped. The study also analyzes the approach of Narrative Medicine (NM) which proposes patients the "space" in which to create their narratives. The findings show that both patients as well as doctors try to create narrative coherence based on cultural and partially historical expectations. Generally, the analysis indicates that narrative and historically and culturally determined politeness plays an essential part in forming relevant meanings in medical interactions between the doctor and the patient.

Abstrakt

Celem artykułu jest stanu wiedzy dotyczącego tego, jak lekarze i pacjenci próbują kształtować interakcję na wspólnej płaszczyźnie komunikacyjnej ze szczególnym uwzględnieniem historycznego oraz współczesnego zarysu kształtowania komunikacji w obrębie teorii grzeczności. Badanie ma na celu ukazanie, że podejście medycyny narracyjnej może stanowić istotny wkład w pogłębianie tego rodzaju badań. Przeprowadzone badanie empiryczne wskazuje, że narracyjna oraz historycznie i kulturowo uwarunkowana grzeczność odgrywa istotną rolę w kształtowaniu istotnych znaczeń komunikacyjnych w dyskur-

sie medycznym, a tym samym w znaczącym stopniu wpływają na budowanie pozytywnych interakcji w relacji lekarz-pacjent.

Key words: medical discourse, narrative medicine, patient-doctor communication
Słowa kluczowe: dyskurs medyczny, medycyna narracyjna, komunikacja lekarz-pacjent

The most significant characteristic of language seems to be communication, particularly when interlocutors are doctors and patients. Patients, because of their illnesses, experience a mental burden and they require professional help to relieve themselves physically as well as psychologically. The type of behavior which is anticipated from doctors is 'behaving well', or rather 'politeness'. As Gino Eelen[1] proposes, the idea of politeness recalls Penelope Brown and Steven Levinson's[2] politeness theory, which has been exploited in many studies[3]. Moreover, many researchers have examined medical communication, particularly from the viewpoint of discourse as well as conversation analysis, considering the aspect of politeness as well[4].

In Polish studies on medical communication, there are some descriptions of doctor-patient interactions[5] that discuss various aspects concerning medical narrative. However, more research is needed to offer more complex viewpoint on the aspect of medical communication. The research of interactions between doctors and patients from the viewpoint of discourse pragmatics will not only add to current studies concerning medical communication in Poland but will

[1] G. Eelen, *A Critique of Politeness Theories*, Manchester, 2001.

[2] P. Brown, S. Levinson, *Politeness: Some universals in language usage*, Cambridge 1987.

[3] M. Nevala, *Accessing Politeness Axes: Forms of address and terms of reference in early English correspondence*, "Journal of Pragmatics" 2004, v. 36, pp. 2125–2160; M. Bazzocchi, *Doctor-patient communication in radiology: a great opportunity for future radiology*, "Radio med" 2012, no. 117, pp. 339–353.

[4] R. Wodak, *Critical discourse analysis and doctor-patients' interaction*, [in:] *The construction of professional discourse*, ed. B. Gunnarson, P. Limmell and B. Nordberg, London 1997, pp. 173–200.

[5] M. Nowina Konopka, *Komunikacja lekarz – pacjent Teoria i praktyka*, Kraków 2016; A. Zembala, *Modele komunikacyjne w relacjach lekarz – pacjent*, „Zeszyty Naukowe Towarzystwa Doktorantów UJ. Nauki Ścisłe" 2015, v. 11, pp. 35–50; K. Stefaniak, *Władza i tożsamość w komunikacji lekarz – pacjent*, Wrocław 2011; *Jak rozmawiać z pacjentem? Anatomia komunikacji w relacji w praktyce lekarskiej*, red. A. Ostrowska, Warszawa 2017.

also explain discourse as well as pragmatic aspects with the use of data collected form the conversations by native speakers of Polish.

In this study, special attention will be given to interaction between doctor and patient in Polish, which is examined from the perspective of the pragmatics, discourse and aims at enhancing register studies of the Polish language taking into consideration observations proposed by Susie M. Barone[6]. Familiarizing oneself with the pragmalinguistics as well as sociolinguistics of medical interaction appears to be a part of the obligation of communicative competence in the given language. Standard doctor-patient communication involves three parts, namely: interview (sometimes in the form of diagnosis), treatment as well as follow-up[7]. Every part has its own structure and distinguishing characteristics that can be seen and examined also as distinct or as part of a longer discourse. This research will be restricted to the diagnostic facet as it is the most important part of the interaction that completely develops the usage of conversation. This paper discusses the aspect of politeness in doctor-patient interactions in Polish in certain hospitals in Poland[8]. It tries to examine the contextual beliefs regarding the doctor and the patient. The attention is also given to the linguistic forms used in the conversations and the pragmatic acts completed in them. Furthermore, special attention will be given to understand the doctor-patient communication in a private outpatient clinic, focusing on the patient's age and gender and their effect on the politeness strategies employed by the doctor. Some studies focused on interactants' reception of politeness in the hospital. The number of studies that concentrated on the aspects were not been given enough attention to. The limited number of studies, only in the specific context of a Polish hospital, has concentrated on how the cultural, historical, and institutional orientations of customers and doctors[9] clash at the specific stage taking into account the aspect of face and politeness. The results of the research are anticipated to add to current work on discourse analysis, register studies, pragmatics and medical communication in Poland.

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[6] S.M. Barone, *Seeking narrative coherence: Doctors' elicitations and patients' narratives in medical encounters*. Ph.D thesis 2012, https://core.ac.uk/download/pdf/41337614.pdf.

[7] R. Wodak, *Critical discourse analysis and doctor-patients' interaction*..., pp.173–200.

[8] The data was obtained from private clinics in Poland (dolnoslaskie region). The process of data collection started on the 10th March 2017 and finished on the 30th June 2018. All the doctors took part in a special course aiming at improving their communicative skills.

[9] S. L. Graham, *Hospitalk: Politeness and hierarchical structures in interdisciplinary discharge rounds*, "Journal of Politeness Research. Language, Behaviour, Culture", 2009, v. 5, is. 1, pp. 11–31.

This paper also aims at exploring how narratives offered with narrative medicine (NM[10]) approach[11] can shape the process of communication within medical interactions, concentrating on how patients use linguistic processes which show agency as they administer their health conditions. The investigation tries to comprehend the connection between doctors' elicitations and narratives that are offered by patients to add to awareness of communicative events in various clinical settings in Polish hospitals aimed at discovering how discourse analysis could be exploited in applied linguistics research concentrating on medical discourse. John Creswell[12] indicates that more comprehensive narratives result in better patient contentment and more precise diagnosis. Obtaining understanding into aspects of narrative as well as identity that is historically and culturally determined within the process of creating medical interactions seems to be also crucial to understanding how to fulfill patient needs more efficiently.

The assumption of this examination is that there appear to be a narrative that is either implicitly or explicitly recommended by the patient in contact with the doctor as well as that this narrative occurs to be prompted by the health care provider[13]. Narrative within the NM context is described as stories told in words, gestures, silences, tracings, images, and physical manifestations recognizing that 'any phenomenon has to be contextualized in order to be understood'[14]. The method employed in this research is established on the identical assumption; specifically, that the patient proposes a narrative, and it is the responsibility of sources to offer the prompts, 'space', and considerate person needed for the narrative to be reported by the patients.

Theoretical framework

Doctor-patient communication tends to be an example of institutional talk, as it is strictly connected with the 'institutions', i.e. with the settings in which it takes place. These institutions and organizations, such as hospitals or clinics, appear to determine Norman Fairclough's social context[15]. In his opin-

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[10] NM (abbreviation) narrative medicine – it will be used in the following text to refer to the concept of narrative medicine.

[11] R. Charon, *Narrative medicine: Honoring the stories of illness*, New York 2006.

[12] J. Creswell, *Narrative, pain, and suffering*. [Review of the book *Progress in pain research and management*], "New England Journal of Medicine" 2005, no. 353 (15), p. 1637.

[13] R. Charon, *Narrative medicine: Honoring the stories of illness...*, passim.

[14] *Ibidem*.

[15] N. Fairclough, *Language and power*, London 1989.

ion, all forms of discourse are formed by these organizations which are in turn formed by wider power relations. Joanna Thornborrow[16] states that institutional discourse can be considered as (1) goal oriented, (2) having differentiated, pre-inscribed participant roles, and (3) asymmetrical. These features may be incomplete, but they propose an indispensable insight into what institutional discourse is and how it can affect the process of communication. The doctor and the patient meet to offer the doctor a chance to gain necessary information, make a diagnosis and help (or try to help) the patient. This goal orientation determines most aspects of the interactions. The reason is that patients provide their doctors with information about their lives – sometimes, it may be information of a very intimate character – whereas doctors usually do not reciprocate. The institution establishes roles for both doctors and patients. It is the role of the doctor to collect the essential information and help the patient, and it appears to be the role of the patient to offer the information with the intention of getting a diagnosis and treatment. Furthermore, doctors are typically those who initiate as well as terminate the process of interviews[17]. Offering information and information withholding appear to be significant from the viewpoint of the patient and doctor. Patients nearly always want to obtain as much data as possible, doctors occasionally tend to withhold it[18], and the doctors' ability to control information generates an elementary asymmetry in the relationship between doctors and patients. Nonetheless, it seems clear that doctor-patient communication is in many respects asymmetric, with doctors wielding more power and patients less. As stated by John Heritage[19], participants in institutional confronts employ a sequence of linguistic as well as interaction resources specific to the situation and consistent with the linguistic and cultural competence concerning all participants. Heritage added that the features of institutional interaction, namely[20]: "(i) the participants [hold] some specific roles, (ii) a series of constrictions characteristic of the institutional context are [significant] and (iii) inference marks and specific procedures [related]

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[16] J. Thornborrow, *Language and interaction in institutional discourse*, Harlow 2002.

[17] J. Beran, *Doctor-patient communication: Part I – Introduction*, Prague 1999.

[18] H. Waitzkin, *Information giving in medical care*, "Journal of Health and Social Behavior" 1985, v. 2 (2), pp. 81–101.

[19] J. Heritage, *Conversation analysis and institutional talk*, [in:] *Quantitative research: theory, method and practice*, ed. D. Silverman, Sage 1977, pp. 161–182.

[20] C. Valero-Garces, *Interaction and conversational constrictions in the relationships between suppliers of services and immigrant users*, "Pragmatics",2002, v. 12, is. 4, pp. 469–495.

to each institution [occur]." The features above are accompanied by the following elements: "(i) assignment of the participants' roles, (ii) general structure, (iii) sequential organization, (iv) lexical choice, as well as (v) asymmetrical relationships." (ibid.) With respect to doctor-patient communication, scholars have made extensive remarks in their studies. Malcolm Coulthard and Margaret Ashby[21] noticed the reappearance of doctor-instigated exchanges in diagnostic communication between the doctor and patients. As stated by them, if an individual tries to begin conversation, the doctor does not think he/she has a duty to reply. They notice that the communication is based on transfer swaps, in which data is transmitted from the responding patient to the eliciting doctor, along with matching exchanges, in which the patient offers the doctor some information to be approved. The negotiation of a mutual orientation between doctor and patient arises through series (sequences) of interactions in order, up until the doctor is completely able to match a medical diagnosis with the patient's predicament. Moreover, Moira Chimombo and Robert Roseberry[22] state that medical communication seems to be a goal-oriented process that reflects participants, medium, strategies, and setting as well as theme.

It should also be noticed that doctor-patient communication can be described, besides the above stated, by a high level of formality and detachment. The formality and detachment are noticeable in employing the concept of politeness. The idea of politeness and face concur. Politeness, which is noticeable in conditions of social distance or intimacy, is how individuals demonstrate awareness of another person's face, the face being technically identified as the 'public self-image of a person'[23]. Academics have recommended numerous maxims of politeness[24], particularly the subsequent ones suggested by Geoffrey Leech[25] have been given wide consideration: tact, generosity, approbation, modesty, agreement, sympathy and Pollyanna. Leech's input to this view of

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[21] M. Coulthard, M. Ashby, *A linguistic description of doctor-patient interviews*, [in:] *Studies in everyday medical life*, ed. M. Wadsworth and D. Robinson, London 1976.

[22] M. Chimombo, Robert L. Roseberry, *The power of discourse: An introduction to discourse analysis*, London 1998.

[23] E. Goffman, *Interaction ritual: essays on face-to-face behavior*, New York, Garden City 1967; P. Brown, St. Levinson, *Politeness: Some universals in language usage*, Cambridge 1987; J. Thomas, *Cross-cultural pragmatics failure*, "Applied linguistics" 1995, v. 4, is. 2, pp. 91–112.

[24] R.T. Lakoff, *The logic of politeness; or, minding your p's and* q's, Chicago 1973; G. Leech, *Principles of pragmatics*, London 1983; B. Fraser, *Perspectives on politeness*, "Journal of pragmatics" 1990, pp. 219–236.

[25] B. Fraser, *op. cit.*, pp. 219–236.

politeness was to offer explanations for the factors which guide and constrain conversations by elaborating on Grice's Maxims. Limitations recognized with Leech's approach comprise the fact that the maxims do not address the expressive aspects of language[26], or the way in which language is employed to address interpersonal issues[27].

Fundamental to Penelope Brown and Stephen Levinson's[28] comprehensive theory of politeness is the management of cooperative relations through considering positive and negative face. Brown and Levinson's theory of politeness is based on Erving Goffman's[29] observation that when individuals cooperate, they continuously take care of maintaining a commodity called face[30]. As Judith Spiers[31] remarks, it is significant to comprehend that although face can be associated with the concept of "self", the comparison is of restricted utility, since face does not imply something that is inherent in the person, but rather is demonstrated through interactions with others. However, as Brown and Levinson[32] clarify, face-needs and the performance of facework are not something that one is inevitably aware of. Because of this dependence on others for the satisfaction of face-needs, identified as *mutual vulnerability*[33], it seems to be in everyone's interests to take part in each other's face-needs. One's mutual face-needs are accomplished and protected through facework and the employment of politeness strategies. Positive face is improved by offering and getting affection, solidarity, positive evaluations, appreciation of individual qualities and by displaying understanding[34]. On the other hand, negative face is engendered by imposing the individual's need for autonomy, territoriality and independence in thought and action. Negative face is alleviated by respecting the individual's desire for privacy and independence, giving the option of not acting/getting involved, respecting hierarchical changes and being conventionally polite. Any utterance

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[26] J. Spiers, *The use of facework and politeness theory*, "Qualitative Health Research" 1998, v. 8, is. 1, pp. 25–47.

[27] M. Sifianou, *Politeness phenomena in England and Greece*, Oxford 1992.

[28] P. Brown, S. Levinson, *Politeness: Some universals in language usage*, Cambridge 1987.

[29] E. Goffman, *Interaction ritual: essays on face-to-face behavior*...

[30] S. Pinker, *Indirect speech, politeness, deniability, and relationship negotiation: Comment on Marina Terkourafi's The Puzzle of Indirect Speech*, "Journal of Pragmatics", 2011, v. 43, is. 11, pp. 2866–2868.

[31] J. Spiers, *The use of facework and politeness theory*..., pp. 25–47.

[32] P. Brown, S. Levinson, *Politeness: Some universals in language usage*..., p. 58.

[33] *Ibidem*, p. 61.

[34] J. Spiers, *The use of facework and politeness theory*..., pp. 25–47.

has the possibility to threaten face, to be a face threatening act (FTA)[35]. Brown and Levinson[36] recognized five politeness strategies included in the management of face, namely:

• 'Bald on record' – referring to efficient utterances (in terms of Grice's quantity maxim) that do not comprise any mitigation, e.g. the utterance "deep breaths";

• 'Positive politeness' – protecting and attending to an individual's positive face;

• 'Negative politeness' – concerning the maintenance of the individual's (either the speaker's or hearer's) negative face, i.e. maintaining their autonomy, avoiding imposition and maintaining appropriate social dissonance;

• 'Indirect, off-record' – strategies denote utterances that do not make the illocutionary intent explicit, but rather, in order to protect face and provide the listener with the option of replying or not, the intention is only hinted at;

• 'Not doing the FTA' – the individual perceives the speech act to be too threatening, so chooses not to perform it..

The strategy names indicate the degree of mitigation used (whether consciously or unconsciously) to soften utterances with the first, 'Bald on record' involving the least mitigation and the last, 'Not doing the FTA' containing the most. Brown and Levinson continue to elaborate, clarifying how the diverse components of one's utterances can be comprehended and understood concerning face management. At this micro level they denote the utterances which attend to face as outputs[37]. Brown and Levinson offer a limited explanation concerning the hierarchy of these charts, placing super-strategies at the "highest level" and "output strategies" as "the final choices of linguistic means to realize the high[er order] goals"[38]. They also clarify that they employ the word 'strategy' to denote a plan at any of these levels, depending on the context to make clear which hierarchical level is [being] talked about[39]. To this end, they frequently employ the terms strategy, mechanism and output interchangeably. Brown and Levinson do not make clear whether these "final choices" are the words that individuals say or whether what is at stake is what individuals say plus their intention when saying it. Specifically, they do not obviously state

[35] P. Brown, S. Levinson, *Politeness: Some universals in language usage...*, p. 61.
[36] *Ibidem*, p. 61.
[37] *Ibidem*, p. 58.
[38] *Ibidem*, p. 92.
[39] *Ibidem*, p. 93.

whether locutionary or illocutionary force is the focus. Yet, the outputs listed appear generally to be intentional in nature and this interpretation is strengthened in their intricate description of the various super-strategies, mechanisms and outputs. Utterances can involve the employment of a mixture of strategies, i.e. outputs from more than one of the super-strategies[40]. Brown and Levinson[41] believe that the leading strategy within the discourse allows one to determine the level of threat that the speaker perceives the speech act to hold.

There seems to be a range of principles controlling language exploitation which competent users may or may not be explicitly aware of. Patients nowadays are frequently treated as consumers with specific expectations of service providers such as medical health care providers. Furthermore, they are encouraged to express themselves and make choices concerning the management of their own health. At the same time, as these factors try to raise the status of the patient within the consultation, many other ongoing matters can constrain patient involvement. These include fear, pre-existing expectations regarding social norms, emotional or physiological problems affecting sense of control, and their inferior position as layperson. Sequentially, cooperation hinges on the maintenance of friendly relations, a significant aspect of doctor-patient communication[42] and the one which can be endangered by breaches to contextual norms. Brown and Levinson's (1987) theory of politeness and facework offers a useful device with which one may explore the linguistic strategies employed to obtain cooperation and to manage FTAs. Considering the theoretical aspects presented above, the following research question is investigated in this paper: Do the patient's age and gender influence the politeness strategies used by the doctors?

Taking into account the aforementioned aspects, one should be aware that the concept of politeness can contribute to creating coherence within NM as it exploits various discursive strategies to make the text cohesive and coherent. The most prominent pioneering work linked to NM has been conducted by Charon[43]. She created the idea and invented the concept "Narrative Medicine" (NM). NM developed from the medical as well as comparative literature per-

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[40] *Ibidem*, pp. 17–21, pp. 230–232.

[41] *Ibidem*, pp. 74–84.

[42] P. Ranjan, A. Kumari, A. Chakrawarty, *How can Doctors Improve their Communication Skills?*, "Journal of clinical and diagnostic research: JCDR" 2015, no. 9(3), JE01–JE4.

[43] R. Charon, *Narrative medicine. Litsite.* Retrieved September 2018, from http://litsite.alaska.edu/healing/medicine.html

ceptions, and is therefore, grounded in narrative theory. The NM approach tries to see a person as an individual rather than only concentrating on signs and disease. It also attempts to cultivate empathy among healthcare staff for their patients.

One has to be aware that recognizing historically distinctive patterns, especially when one takes into account the aspect of politeness, seems to be crucial. Brooks[44] underlines the fact that every social history of common cultural traditions predefined all important figures as well as events that tends to shape imminent activities in the course of history. The same seems to hold for the approach of politeness and constructing narratives in the doctor-patient interaction. As Hofstede[45] mentions all linguistic aspects take into consideration historical and cultural aspects that are later transformed into altered norms and principles that are widely adopted in genuine cultural practices. While analyzing the patterns of politeness, one can see that the reality that is a sociocultural construct based on past experiences and verbal-interactional elements have been passed down to contemporary society through the actual text record that is a sum of all cultural and linguistic exchanges that evaluated through the time. What is clearly visible is the that there are challenging aspects that need to be analyzed taking into account the fact that all doctor-patient interactions are results not only of doctor-patient interactions but also historical and cultural predetermined outcomes of mental structures participants bring into the process of communication.

Results in this paper show that the scope of coherence in medical confronts may also involve less serious, chronic cases of illness, where the absence of coherence itself may tell portion of the patient's story and indicate that patients take for granted some aspects that are not conveyed in the process of communication to the doctors. It also underlines that the concept of politeness can contribute to achieve the desired coherence while shaping various narratives. Moreover, this discussion indicates that NM appears to be a clinical approach which permits for, but also supports, the broad scope of narrative coherence. It shows that the attention is given to narrative skills which doctors can create with the aim of "reading" these complex, and frequently, less coherent patient narratives.

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[44] T.Brooks, *The Confusions of Pleasure: Commerce and Culture in Ming China*, Berkeley, University of California

[45] G. Hofstede, *Culture's Consequences: Comparing Values, Behaviors, Institutions, and Organizations across Nations*, Sage 2001.

Methodology

The current research employs a methodology that reflects the patients' gender, age and some parts of their interaction with doctor and uses the written account of observation of the patients. The observation sheet is constructed in a way that splits patients into groups of males and females who are younger or older than the doctor. Furthermore, after requesting the essential consent from both groups, the doctor and patients' conversation was documented and transcribed. Some parts of the conversation were taken down to make the transcription phase easier in terms of recognizing which voice belongs to a patient, considering his/her age. As the observer wanted to maintain the patients' privacy, he/she did not ask their name. After that, as stated by Brown and Levinson's politeness theory, the strategies employed by the doctor are assessed. Also, the researcher put some questions to doctor at the ending of the research to classify the doctor's ideas about doctor-patient interaction. The participants in this study involved 50 patients (25 male with 13 younger and 12 older, and 25 females with 12 younger and 13 older), patients in a clinic, and the doctors have been practicing about 10-20 years as specialists.

The motivations for selecting various specialists among doctors and patients are the following: (1) as the clinic is a diagnostic ward and this branch copes with a higher number of patients, other clinics ask some of their patients to contact this clinic for diagnostic reasons. Consequently, the number of observations rises; and (2) as Massimo Bazzocci[46] proposes, speech has a crucial role in a doctor's profession; likewise, the politeness issue seems to be a very delicate one, and there would be communication in detail to describe the relationship between doctor and patient, e.g. addressing as well as sharing talks about everyday life, so again clinics would be a better place to examine this rapport in the medical area.

Taking into consideration this framework, narratives are also seen as a way in which patients encounter ill health, promote empathy that can be shown in the form of various politeness forms as well as understanding between doctor and patient, help in the construction of meaning[47] and may provide valuable analytical clues and categories[48]. Narrative competence within the NM approach

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[46] M. Bazzocchi, *Doctor-patient communication in radiology: a great opportunity for future radiology*, "Radio med" 2012, v. 117, pp. 339–353.

[47] C. Riessman, *Narrative methods in the social sciences*, Sage 2008.

[48] T. Greenhalgh, B.Hurwitz, *Ethics and narrative*, "British Medical Journal" 1999, no. 318, pp. 48–50.

is expected to build a higher level of doctor empathy toward the patient, it can also be achieved by means of politeness, even it is not openly stated that the NM approach can take advantage of that. This empathy is established as doctors evaluate their own experiences with life, illness as well as other patients' illnesses. Taking into account the narrative competence, the doctor may then better determine what is salient to an illness and what is not[49]. The patient's narrative is critical to the doctor's capability to comprehend how each medical event is situated in a patient's life.

Results

In Table 1, presented below, politeness strategies are examined through four categories, considering the aspects of patients' age and gender. The results display how many times each strategy was employed.

Table 1. Exploited politeness strategies

	Younger/ Female	Younger/ Male	Older/ Female	Older/Male
Bold on Record	9	12	8	10
Positive Politeness	4	2	0	2
Negative Politeness	1	0	7	3
Off-Record	0	0	0	0

It is evident from the figure that 'Bald on Record' seems to be the most frequently chosen approach. For example, the doctor instructed a twenty-nine-year-old, female patient to „hold your breath for a minute!", correspondingly, he said to a forty- six-year-old male patient "take a deep breath and hold". These examples demonstrate that the patients are younger than doctor and the gender did not affect the message as the number of 'Bald on Record' is the same for both genders thus the approach of doctor is direct communication, whether to female or male. It is less likely for the doctor to select 'Bald on Record' while

[49] R. Charon, *Narrative Medicine: Honoring the Stories of Illness*...

speaking to older/female patients. Conversely, the highest value of 'Bald on Record' is showed with male patients, who are older than doctor; it seems to be astounding as talking to old people involves respect and indirect speech but here, doctor reduces the distance and employs direct sentences – this holds for both male and female doctors.

The other strategy is 'Positive Politeness' which is typically employed by female patients who are younger than the doctor. Employing inclusive forms such as "we" or "let's" specifies positive politeness[50] which is face saving, rather than 'Bald on Record'. For example, the doctor told a twenty-five-year-old female (pregnant) patient "we're going to apply three-stepped diagnostic procedure to..." even though it is only the doctor who will conduct this procedure. In younger/male, 'Positive' and 'Negative Politeness' strategies were not applied; as the patient is younger than doctor and of the same gender, more direct speech might have been favored. In older/female category which as anticipated contains the highest occurrence of 'Negative Politeness', the doctor did not employ 'positive politeness' at all.

The doctor interacts with female and male patients who are older than him/her with more respect and detachment, so the occurrence of phrases such as "please" or "could/can you" demonstrate the higher rate of exploiting 'negative politeness'. In the categories where doctors and patients are of opposite genders, we observe the lowest frequency of 'negative politeness'. It might be stated that as the patients are younger than the doctor, so she/he perceives no necessity to use distant manners.

The zero frequency of 'off-record' and 'don't do the FTAs' signifies a normal and anticipated distribution, as the doctor-patient communication involves a kind of transparent relationship and patients should share their problems rather than employ implications or signs, and the doctor should feel comfortable requesting information without difficulty with his/her patients.

Taking into account the aspect of the solidarity and politeness criteria with four groups that are examined where the age and the gender of patients constitute the independent variables, one can observe in female patients who are younger than doctor, the smallest amount of solidarity was chosen but the most well-mannered formulations were employed. For example, while doctor was interviewing a twenty-nine-year-old female patient: "Have you just had

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[50] D. A. Morand, *Language and power: an empirical analysis of linguistic strategies used in superior-subordinate communication*, "Journal of Organizational Behavior" 2000, v. 21, pp. 235–248.

a surgery?", he employed singular 'you', which indicates sincerity or solidarity; yet, it occurred only once. Conversely, the use of addressing phrases plural 'you' might show politeness.

In male patients who are younger than doctor, the state of affairs is vice versa as the doctor employed mostly singular 'you' like "Just take off your shirt". It is obviously grounded in the fact that both interlocutors are of the same gender and the doctor feels no need to set a distance between himself/herself and the patient; they take advantage of some kind of man-talk with more honest behaviors. Therefore, linked to the higher level of solidarity, politeness is less detected in terms of the above revealed explanations.

In female patients who are older than the doctor, both solidarity and politeness are balanced. While the doctor uses singular 'you', he/she increases the solidarity as a means of sincerity, using such phrases as 'my dear', 'my sweetie' to raise politeness.

In male patients who are older than doctor, the doctor frequently uses singular 'you'. For example, the doctor informs a fifty-eight-year-old male patient "Now, you clean..." hence, the distance between doctor and patient reduces and sounds more like a sincere talk. Conversely, with addressing phrases like "man, you know", the level of politeness rises, since the doctor shows his respect to patient but once more because of a kind of man-talk, solidarity is higher than politeness. In this figure, the most noticeable result is that the doctor makes no concession to age and gender with all groups except for younger/female in which she/he behaves politely and on the other hand chooses solidarity with the same frequency in other three categories.

While taking into consideration NM, one can observe that doctors appreciate and promote open-ended narratives because this is a natural element of conversation, which is the most likely means for conveying unsolved and problematic life events[51]. As one can observe, it employs various strategies that are present within the politeness concept. Within the medical encounter, doctors may need to adapt the open-endedness of patients' narratives as patients communicate and seek to construct meaning of their unsolved health conditions even without comprehending what has happened and why.

The following example is derived from interaction 1, echoed for the reader's convenience, and presents an example of how doctors and patients seem to move through a narrative even when the story may not be fully solved. In the

[51] R. Charon, *Narrative Medicine: Honoring the Stories of Illness*...

example below the doctor's feedback, *OK,* tends to suggest that he understands what the patient has stated thus far and is expecting the next part of the patient's story. In this same quotation, the patient communicates a lack of understanding of what essentially caused her to fall by assuming that her foot *must have slipped*:

Example 1 (patient – female, doctor – male):

D (doctor): OK. Could you tell me what brought you here?
P (patient): You know, I was walking [...] and I went to cross the street at the curb [...] and ***my foot has slipped****.*
D: OK. I fully understand you...[52]

Even though this patient's narrative is not entirely resolved regarding why the event she defines has taken place, it can be distinguished from interaction in the example 2, where the patient's narrative appears to leave much of the meaning of the events without resolution even if a lot of linguistic support is offered in the form of polite expressions:

Example 2 (patient – male, doctor – male):

D: Nice to see you again. I hope you feel better. Would you like to tell me how you feel?
P: [...] about the past two weeks [...] I don't think the XXXX is working anymore and I don't think I need to go on with it.
D: I completely understand you. Would you like to suggest a solution?
P: Really? I would be incredibly open to stay on the XXXX, but it would be much better if you could replace it with another XXXX drug.

This example shows the type of open-endedness the doctor might encounter in proposing the patient "space" in which to speak without presenting elicitations to lead to a more completed narrative. By proposing the patient "space" without the guidance of more regular elicitations, the patient may or may not be able to present a concise, more complete narrative. That open-endedness can happen as the doctor offers a polite opening to the patient, encouraging the patient to state his/her point of view at the same time.

Another example shows that additional staff members seem to be also an integral part of the interaction as they help the healthcare staff to make some

[52] Translation from Polish into English – A.K.

decisions. As Susan Ehrlich[53] suggests, "participants who are not directly and actively involved in an interaction can nonetheless influence the meanings and understandings that are assigned to that interaction":

Example 3 (patient – female, doctor – female):

D: Excuse me, there's staff there and I need to go out.
P: You always go out there and have a look.
D: I understand that you may not feel comfortable with me leaving the room, but I try to keep up to date records and I will have to ask you some extra questions. Would it be OK with you?

The significance of these extra staff members in this part of the interaction is that they did not offer the patient any information, the patient was requested to supply information about her medical history. Even though the extra staff are not adding to the interaction through words, their role and accountability for patient charting add to the development of the patient's narrative. As it can be seen from the example above, the doctor tries to stick to politeness principles to give the patient a chance to decide about the process of treatment.

Discussion

Taking into consideration the research question that aimed at finding whether the patient's age and gender influence the politeness strategies exploited by the doctors, the results showed that the patient's age and gender can affect the doctor-patient interaction. Considering the younger/female patients, all the obtained data confirms that doctor's attitude toward those patients was quite direct with 'Bald on Record' utterances, since at the same time, those patients have the second highest number of 'Positive Politeness' strategies used by the doctor. Correspondingly, the 'Negative Politeness' strategy used with this group comprises the third place among all four categories, which indicates a low frequency. Since the patients are younger than the doctor, the strategies showing distance are not exploited.

In addition, from a general perspective the doctor's interaction with male patients, whether younger or older, is nearly always direct. When a younger/male patient is examined, the doctor (male) employed a less distant attitude, in

[53] S.Ehrlich, *Trial discourse and judicial decision-making: Constraining, the boundaries of gendered identities*, [in:] T. Van Dijk, *Discourse Studies*, London-Sage 2007, p. 196.

other words, favored direct utterances. Still, it was astonishing that the highest number of 'Bald on Record' appears in older/male patients, as it was anticipated that direct sentences would not be used, but rather polite manners with old people. Conversely, bearing in mind the use of 'Positive Politeness' and 'Negative Politeness' with the older/male group, the significance of age is observed again. Furthermore, in the interview, the doctor talked about the older/male patients feeling more uncomfortable. This indicates the doctor's creating a balance between the age and gender factors.

The doctor is also balanced in terms of results with older/female patients, since 'Bald on Record' and 'Negative Politeness' strategies share the same numbers. Yet again, the doctor has tried to display both respect and create sympathy and solidarity with this group. It can be determined that in this research, the age and gender are significant issues in doctor-patient interactions. Cultural values are of vital significance in defining the strategy exploited. For example, in both female and male older groups, more 'Negative Politeness' strategies are used more frequently in comparison to the younger group of both genders. In Polish culture, people who are old are valued, so the direct speech with imperative sentences which specifies the 'Bald-on-Record' strategy is not exploited but more polite behaviors are favored. Similarly, within the group of the same age but different genders (i.e. younger/male & younger/female and older/male & older/female), the female gender is also appreciated more, which indicates another aspect of cultural values. Generally, the groups to which the most direct (impolite) to most indirect (polite) strategies have been used are ordered in the following way: 1) younger/male, 2) younger/female, 3) older/male, and 4) older/female. Both female groups (both younger and older) are treated with less solidarity and more politeness in comparison with male groups (both younger and older) who are treated with more solidarity and less politeness. This study shows that the doctor-patient communication has its own standards but is still culture-oriented. This study was conducted in Poland, so the same outcomes might not have been obtained if the examination were conducted in a country which has different cultural features. Moira Stewart, Ian McWhinney, and Carol Buck[54] described the doctor-patient relationship "as reflected by the doctor's knowledge of the patient's problems, psychological and social

[54] M.A. Stewart, I.R. McWhinney, Carol W. Buck, *The doctor/patient relationship and its effect upon outcome*, "Journal of the Royal College of General Practitioners" 1979, no. 29(199), pp. 77–82. Retrieved on September, 25, 2018 from: http://pubmedcentralcanada.ca/pmcc/articles/PMC2159129/.

as well as physical"; however, the doctor's awareness did not "significantly affect the patient's satisfaction". This is a power-related interaction, where doctors hold the higher status. Yet it can also be observed that some doctors' practice is rejected by patients only because of a lack of healthy communication between them and doctors, even if the doctor holds a highly valued medical knowledge. Thus, cultural medical awareness training might be included in medical education. As Evelyn Verlinde, Nele Laender, Stephanie Maesschalck, Myriam Deveugele, and Sara Willems[55] state, there is a "growing interest in patient's perception of doctor-patient communication and doctors' medical knowledge should be enriched with empowering verbal communicative skills". It is worth including an education program which contains both medical and cultural norms to improve the process of communication between doctor and patient. Consequently, the better they communicate with patients, the better the outcomes of medical treatments.

These samples that were selected to display how the NM concept and politeness interrelate with the procedure of generating a narrative designate offering "space" aspect of the NM approach to the degree that the patient's narrative is accomplished completely in spite of the great question occurrence and the restricted amount of "space" in which the patient was offered a chance to speak in relation to the length of the medical appointment. This might indicate that there are additional tactics which might prompt a more complete patient narrative, providing the particular condition of a patient. Furthermore, the NM approach has a tendency to allow for narratives which are more or less coherent by offering patients "space" in which to speak with minimum feedback and disruption from the doctor, at the same time conform the underlying regulations of politeness in language.

What is shown in this interaction through the framework of NM is the doctor recommending the patient space through evocations as well as feedback which tend to suggest that the doctor offers himself/herself to listen to the patient and to be of service. In summary, the doctor is challenged to generate narrative coherence from the abundance of data the patient presents in a less-than-coherent manner. That information can be obtained counting on a variety of politeness techniques that can be incorporated in the process of generating discourse that often have cultural and historical basis..

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[55] E.Verlinde, N. De Laender, S. De Maesschalck, M. Deveugele, S. Willems, *The social gradient in doctor-patient communication*, "International Journal for Equity in Health" 2012, v. 11, is. 12, pp. 1–14.

Consensus is not achievable without adequate knowledge concerning the patient's situation. Though patients' narratives are shaped by doctors' elicitations and the sort of reporting fear, they also seem to be affected by several factors that go beyond the range of the medical set, doctor's elicitations as well as discursive strategies, e.g. politeness. These intricacies impact and shape the advancement of patient narratives, which frequently lack typical, explicitly depicted narrative structure and coherence, despite efforts by both participants.

Recommendations for future research

There is much possibility here for further research. There are no reports in the literature that any of the claims suggested above have been combined into healthcare practitioners' communications skills training elsewhere. Examination in this area and implementation as part of a well-designed trial would permit more specific recommendations. Studies collecting patients' feedback would also be valuable and would add some rationality to the results here. Another area for examination could be that of the relationship between positive politeness and rapport structuring. Additional research in this area concentrating on the ability to manage facework flexibly, i.e. to recognize the essential variation in individual wants for attention to positive and negative face, has the potential to be most informative. Moreover, there are also some reasons for further discovering the position of narrative in consultations as it may affect the communication process involving the doctor and the patient.

Conclusion

From a linguistic perspective, generating a cooperative environment within the consultation encourages friendly relations and collaboration. Yet, the way in which suggestions are essentially framed with the aim of achieving this kind of environment does not create chances for alternative ideas to be articulated. Comprehending politeness strategies would simplify reflection on why people say what they say and raise awareness of the range of functions as well as effects of speech. From the evidence offered here, these would also comprise the possible effects of ambiguity in relation to decision-making that results from the use of indirectness, and the importance of the role of small talk in helping some patients to find a way of contributing. Appreciation of this latter element may make practitioners more aware that such talk can act as a medium for offering additional information that might otherwise remain unspoken.

This research contributes to the work of politeness theory by presenting a unique example of the way in which politeness strategies have been noticed in a group of Poles, in primary care consultations and emphasizes areas in which the teaching of such theories could be presented. Its attention to face threat and the way in which positive politeness can raise it offers a platform for better communication of the problems inherent in invitations to agree and consultation styles focused on cooperation. To fully comprehend the implications of these results for clinical practice further research is required. A significant starting point might be to analyze how practitioners can maximize positive politeness as a means of rapport to encourage contribution without generating an environment oriented toward agreement.

The most valuable outcome from this study was indication that doctors and patients tend to constantly attempt to create narrative coherence throughout medical interactions by exploiting various discursive devices, especially the concept of politeness. This finding offers a discourse analytic frame from which provides the information how these participants co-construct patient narratives and identities, especially in interactions relating to chronic illnesses. This understanding makes an essential impact on the area of discourse analysis of medical interactions by establishing the framework for analysis, which improves the comprehension of how patients' narratives as well as identities are co-constructed. The research offered insight into how, through this process, doctors and patients represent crucial aspects of their identities as participants placed in medical encounters. It also underlines the aspect of historical and cultural dimension that is present in creating the narrative and politeness in doctor-patient interactions that cannot be forgotten.

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