The Manifestation of Positive Politeness in Medical Consulting Revisited

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Abstract

This paper offers some partial results from a long-term project aimed at an inquiry into the field of medical consulting. The primary goal of the project is to search for communicative strategies of doctors and patients that can convey empathy and trust. Via an interdisciplinary analysis, based on data excerpted from the most recent edition of the British National Corpus (2007), the author brings quantitative and qualitative evidence that doctor–patient interaction has undergone significant modifications, resulting in a social redefinition of the originally asymmetrical roles of the main protagonists. The present paper draws attention to those communicative practices of doctors and patients that are related to the manifestation of positive politeness.

Keywords: medical consultation, British National Corpus, positive politeness

1 Introduction

The present paper reports on an interdisciplinary investigation within the field of medical consulting, with the aim of discussing communicative practices of doctors and patients that are related to the manifestation of positive politeness. With respect to the primary goal of the long-term research, that being a search for discourse strategies of doctors and patients that are capable of conveying empathy[1] and trust, it focuses on a selected number of strategies, most of which can be characterized as patient-centred and/or expressing equality, mutuality, and symmetry in the doctor–patient relationship.

For the purposes of the analysis I have taken advantage of the spoken component of the *British National Corpus* (BNC XML, ed. 2007) and its collection of transcribed and annotated medical interviews. I have selected 50 medical interactions, all of them dyads, with the total extent of the text amounting to 34,376 words. Regarding methodology, I have combined the statistical perspective[2] of medical science with the qualitative viewpoints

of conversation and discourse analysis (cf. Wynn 1995). My findings are compared and contrasted with findings resulting from previous studies on the principle of politeness in doctor–patient interaction, conducted in the 1980s and early 1990s.

2 Politeness: Theory and Practice

Much has been written in recent years on the theory of politeness or the politeness principle, and many definitions of politeness have been advanced. The following four delineations are just random choices from the endless number of relevant sources.

"Politeness is a system of interpersonal relations designed to facilitate interaction by minimizing the potential for conflict and confrontation inherent in all human interchange" (Lakoff 34). "Normal human interaction is governed by a set of culturally determined conventions, (…) often very properly moderated by politeness" (Lyons 300). "Politeness is not only connected with constantly recurring linguistic formulae but in particular with recurrent behaviour patterns, which regulate social interaction and gain their function and significance from the specific constellations for which they are obligatory" (Held in Watts et al. 148). "Politeness is a matter of what is said, and not a matter of what is thought or believed" (Cruse 362).

Despite all of the studies devoted to politeness – and maybe because of their large number –, no agreement has been reached on the concept as such, and we should rather speak of a number of diverse conceptions (for a summary see Wilamová 2005). Probably the most influential and respected work on politeness was written by Brown & Levinson (1987). They distinguish between negative politeness and positive politeness, presenting negative politeness as "the heart of respect behaviour, just as positive politeness is the kernel of 'familiar' and 'joking' behaviour" (Brown & Levinson: 129). In their view, the system of negative politeness consists of five supra-strategies, namely (i) *be direct*, (ii) *don't presume/assume*, (iii) *don't coerce H*, (iv) *communicate S's want to not impinge on H*, and (v) *redress other wants of H's*. The system of positive politeness consists of three supra-strategies (see below).

Brown & Levinson's approach has not escaped criticism. Meier (1995), for example, criticizes the distinction between negative and positive politeness as fuzzy, and rejects "equating politeness with specific speech acts, lexical items, or syntactic constructions" (Meier 381). According to Urbanová (18), the "distinction between formal and informal politeness is functionally more relevant than the above-mentioned distinction between negative and positive politeness". Nevertheless, Brown & Levinson offer quite a delicate system of politeness mechanisms, which I find useful for the purposes of my investigation. Moreover, as the following two examples illustrate, it is possible to distinguish between negative (Example 1) and positive politeness (Example 2). For that reason I label positive politeness strategies in accord with Brown & Levinson as (i) *claim common ground*, (ii) *convey that S and H are cooperators*, and (iii) *fulfil H's want*.

(1) P: *I don't know why I think maybe the tablets helped, but erm I was saying I was kind of having second thoughts whether I was wanting to go on the HRT*[3] *[or*
D: *No.]*
P: *No.*
D: *No chance. No chance. Not, not with your blood pressure like that.*
P: *No er well she didn't say much, but she*
D: *Well, no chance can tell you now.*
P: *Whenever er*
D: *Just get yourself [down.*
P: *And I thought] er and I had wee tablets that you gave me a while ago, Brusdeximit.*
D: *Mhm.*
P: *And I was wondering maybe if I'd be better going back on them.*

(BNC/H5V/18–28)

(2) D: *Cos these are the things that cause.*
P: *Yeah I thought it was soap.*
D: *Mhm.*
P: *And I started see now they've brought out that Dove, the moisturizer, rubbish.*
D: *(ha-ha)*
P: *Crap. Right.*
D: *(ha-ha)*
P: *Good. I've been buying bars and bars of that see.*
D: *((ha-ha)) No it's er*
P: *Rubbish. I said maybe that'll sort it.*

(BNC/G43/36–45)

As is evident from the above examples, the first illustration (the negatively polite behaviour) takes place during the information-gathering phase, whereas the second illustration (the positively polite behaviour) occurs during the phase of diagnosis. It will be interesting to see if there really is a significant correspondence between the number of politeness strategies (positively polite in particular) and the interview sections or the interview participants, and to seek a qualitative explanation for the data. No less important will be to compare and contrast some of the findings related to the manifestation of the politeness principle arrived at in the 1980s and early 1990s (see Chart 1) with the research results I have obtained at the beginning of the 21st century, based on the electronic version of the *British National Corpus* (2007). Such findings can be relevant when considering to what degree the present-day style of doctor–patient communication reflects ongoing social transformations (cf. Furst 1998).

Chart 1: Findings resulting from previous studies on politeness strategies in doctor–patient interaction

Study	Research results
Paget (1983)	Politeness forms are almost entirely absent from the speaking practices of doctors.
Fisher (1983)	Patients very rarely carry out face threatening acts.
Cicourel (1983)	Doctors ignore symptoms presented by patients.
Raffler-Engel (1989)	The use of medical jargon when a doctor talks to his patient makes the doctor appear to be discourteous.
Henzl (1989)	The substitution of the address pronoun *you* by the first person plural pronoun *we* perpetuates social distance between doctors and patients during their communication.
Roter & Hall (1992)	Both positive and negative talk are quite rare and make up a smaller share of doctors' contributions.
Roter & Hall (1992)	Both positive and negative talk are quite common and make up a large share of patients' contributions.
Maynard (1992)	It is possible for doctors to build an interactional environment in which the delivery of medical expertise will not conflict with the lay perspective of their patients.
Heritage & Sefi (1992)	Advice-giving threatens both the positive and negative face of the advice recipient.
Heath (1992)	Patients do offer their version of postdiagnostic accounts, but without challenging doctors' assessments.

(cf. Wynn 1999: 64–68)

3 Quantitative Perspective: Distributions of Positive Politeness Strategies

The distributional summary of positive politeness strategies realized in the material under investigation is as follows (Table 1 & 2). Out of 50 medical consultations, comprising 5525 turns (34,376 words), it was possible to excerpt 178 cases. 133 (75%) of them are due to the initiation of doctors, 45 (25%) are due to the initiation of patients. 67 (39%) come to pass during the information-gathering section, 4 (2%) come to pass during the diagnosis section, and 105 (59%) during the treatment section. 120 (67%) instances can be classified as belonging to the supra-strategy 'claim common ground', 32 (18%) of them as

belonging to the supra-strategy 'convey that S and H are cooperators', and 26 (15%) to the supra-strategy 'fulfil H's want'.

Table 1: Absolute frequency of positive politeness strategies in doctor–patient interaction

	Participant		**Phase**			
Abs.	*Doctor*	*Patient*	*Information*	*Diagnosis*	*Treatment*	**Total**
Common ground	84	36	62	4	52	**120**
Cooperator	30	2	2	0	30	**32**
Fulfil want	19	7	3	0	23	**26**
Total	**133**	**45**	**67**	**4**	**105**	**178**

Table 2: Relative frequency of positive politeness strategies in doctor–patient interaction

	Participant		**Phase**			
%	*Doctor*	*Patient*	*Information*	*Diagnosis*	*Treatment*	**Total**
Common ground	63	80	92	100	49	**67**
Cooperator	23	4	3	0	29	**18**
Fulfil want	14	16	5	0	22	**15**
Total	**75**	**25**	**39**	**2**	**59**	**100**

As Chart 1 suggests, the previous investigation into politeness (both positive and negative) manifested in doctor–patient interaction was either vague or rather fragmented, definitely not anchored in statistical data. For this reason, the above distributional analysis cannot reveal much information of a comparative character; the only exception is a 'cut and dried' rebuttal of Paget's (1983) opinion that politeness forms are almost entirely absent from the speaking practices of medical professionals. It is obvious that doctors (and patients) employ positive politeness strategies quite frequently, throughout the medical interview, and of all selected types (Example 3: *claim common ground*, Example 4: *convey that S & H are cooperators*, Example 5: *fulfil H's wants*). As my previous research (see Černý 2008) pointed out, not only positively polite, but also negatively polite behaviour is embedded in the communication of doctors and their patients.

(3) D: *Mhm.*
P: *I'm not getting to sleep. It's taking me oh quite a while to get to sleep and, and I'm not hearing [too good.*
D: *Right.] Let's have a look in and see if your brains are expanding or what's happening in here. (.) No wonder you're not hearing so good. No wonder you're getting a buzzing in your ears there's a big lump of concrete in there.*
P: *Is there?*
D: *Let's have another look at this. Oh my. For goodness sake. (ha-ha) There's a wee man with a pick and shovel in [(unclear)*
P: *(unclear)]*

D: *Oh aye. It's solid.*
P: *Is it?*
D: *Absolutely solid.*

(BNC/H4U/8–16)

(4) D: *Er nineteen (.) four, (.) ninety three. (.) Er so that gives you another five or ten years before the dry rot sets in.*
P: *I hope so, hope so. (ha-ha)*
D: *Oh that's good. Oh that's*
P: *I sometimes think it's nature's (unclear) wear and tear.*
D: *Ah! You've got years and years and years to catch up yet.*
P: *(ha-ha)*
D: *Years and years and years.*

(BNC/G44/41–47)

(5) P: *Well what really set my mind was when I lost my sister and my brother.*
D: *Mm.*
P: *Cathy and Hughie like, [in two*
D: *Yeah.]*
P: *months smoking.*
D: *That's right. That's right. I mean we we've got a friend and she used to smoke sixty a day, [and she never*
P: *(unclear)]*
D: *even talked about stopping, till her pal, into hospital, a dif a bypass operation. And that was it.*
P: *Enough.*
D: *Tt! That was it. No chance.*

(BNC/H53/28–37)

The calculation of the F-test (see the Appendix) and the Pearson correlation give more straightforward data: (i) the F-test indicates that, statistically, there is a significant distinction between the distribution of politeness strategies 'claim common ground' and 'convey that S & H are cooperators' with regard to the category of participants, which suggests that it is worth examining which strategy is employed more frequently; (ii) it shows that there is also a significant distinction in the distribution of politeness strategies 'convey that S & H are cooperators' and 'fulfil some of H's wants' with respect to the participants, which again suggests that this fact is worth studying; (iii) the F-test demonstrates a significant distinction between the politeness strategies 'claim common ground' and 'convey that S & H are cooperators' with respect to the category of dialogue phases; (iv) it shows that there is also a significant distinction between the strategies 'claim common ground' and 'fulfil H's want' with respect to the phases. Moreover, the correlation (r=0.3896) also gives evidence that there is a significant correspondence between the variables 'dialogue section' and 'type of positive politeness strategy'.

With respect to points *i*, *iii*, and *iv*, it can be said that both participants prefer positive politeness strategies involving 'claiming common ground between speakers and hearers' to strategies involving 'cooperation of S & H' and/or 'fulfilling H's wants'. The explanation appears to be closely connected with the number of substrategies embraced by each category and with the dialogue phases in which it is natural for the particular strategy to take place. As the former category comprises more than half of the total number of substrategies involved (8 out of 15: for details see Brown & Levinson[4]), it could be presumed that it is this variability and richness that supports the language choices. In a way, this is true. Nonetheless, as neither doctors nor patients are familiar with the categories produced by linguists, it must be added that unlike the latter two strategies, which occur almost exclusively in the treatment section, the former strategy is distributed throughout the interview. This is due to the character of the particular strategy. Whilst in 'claiming common ground' the speaker emphasizes that both S & H belong to the same group of persons (Brown & Levinson 103), which may be conveyed during any period of the encounter, the claim that 'S & H are cooperators' and, in particular, 'fulfilments of H's wants' are perspectivized towards the end of the encounter.

Referring to point *ii*, it can be explained by the unbalanced distribution of instances between doctors and patients within the category 'convey that S & H are cooperators' (doctors 30 : patients 2) and a more balanced distribution of instances within the category 'fulfil some of H's wants' (doctors 19 : patients 7).

4 Qualitative Perspective: Positive Politeness Strategies Manifested by Doctors

Having outlined the statistical perspective of the analysis, I will now continue with its qualitative interpretation. What may be stressed as the most significant point, if compared with available research results from the 1980s and early 1990s, is that medical professionals are willing to contribute to a trustful and sharing atmosphere in a medical consultation. By employing a variety of positive politeness strategies throughout the interview, they support courteous and tactful manners, and thus achieve smooth relations with their patients. The fact that medical professionals show empathy and understanding, attention and interest, encouragement and cooperation when interacting with their clients results in social closeness during the act of communication.

More specifically, qualitative interpretations have, for instance, indicated that doctors frequently choose a style of language that patients are familiar with (cf. Raffler-Engel 1989). Usually they switch from medical jargon to more colloquial expressions (Example 6–7). In other words, they try to build an interactional environment in which the delivery of medical expertise does not conflict with the lay perspective of their patients (Maynard 1992). To put it yet more differently, using terminology which is typical of pragmatic discourse, doctors tend to "choose such expressions which minimally belittle the hearer's status", or "cause the minimum loss of face to the hearer" (Cruse 362).

(6) P: *Is it alright to put that on, you know, when it's broken. The skin*
D: *Yes, you've got, you've got to be a bit careful with broken skin because if you put things directly on it, they tend to irritate. It won't do the skin any harm particularly, but it can smart. [And*
P: *Mhm.]*
D: *that might be one good reason for using the er the soaks. The other think I'd recommend, is, using a fine pair scissors, is take off the scaly bits, the bits that stick out, cos they're the bits [that catch*
P: *Mm.]*
D: *and hurt [and*
P: *Yeah.]*
D: *pull the skin apart. And once they're all sticking out, dead and scaly, they're redundant anyway, so you may as well trim it all down. Neaten it up. And you're less likely to catch your hands then. Okay?*
P: *Okay.*

(BNC/GYE/54–62)

(7) D: *It it's a funny little drug it's related to sodium, old sodium, you've got loads of sodium. You take it it everyday as with salt. Er but I I it can replace sodium in certain systems of the body. In fact that's how it seems to work. But because of that you've got to watch it's effects on the kidneys, on the body biochemistry.*

(BNC/G5X/91–91)

The positive talk of practitioners is further enhanced by the frequent use of laughter (Example 8), by showing solidarity (Example 9) and approval (Example 10), by tension release (Example 11), by displaying optimism and involving a high percentage of communication with positive content (Example 12), by giving reassurance (Example 13) and offering support (Example 14), by calming patients and promoting trust (Example 15), by initiating safe topics (Example 16) and by informal address forms (Example 17). Although merely enumerative in character, this information alters Roter & Hall's (1992) standpoint on doctor–patient interaction (see Chart 1).

(8) D: *Turn you into a human being.*
P: *(unclear)*
D: ***(ha-ha)***
P: ***((ha-ha)) You're not kidding.***
D: ***(ha-ha)***
P: *That's what it feels like [(unclear)*
D: *Well]*
P: *especially with the wee one being*
D: *[well,*
P: *ill,] [I mean*
D: *well]*

P: *she's up all night, (unclear).*
D: *Turn you into a human being.*

(BNC/G47/112–124)

(9) P: *And I don't want to go. I'm not one for [holidays.*
D: *No, no.]*
P: *I like being in I it's it's it's your nature, [if if*
D: *That's right.]*
P: *your if your nature's for gadding about,*
D: *I think that's [(unclear)*
P: *okey-dokey,] but if it isn't* ***I mean I like me home. I'm a home bird.***
D: ***That's right. [That's***
P: ***Er]***
D: ***right, I must admit, I'm inclined the same way.***
P: *Yeah, yeah.*
D: *(ha-ha)*

(BNC/G5P/18–29)

(10) D: ***Yeah, you're okay, you can go swimming, it shouldn't do you any harm****. I mean in things like swimming baths are chlorinated so they've got a low bug count anyway, so, so you'll be at low risk of getting anything there.*

(BNC/GYE/79–79)

(11) P: *It's not doing very good.*
D: *Is it not?*
P: *No, it is not. (.) She that er that cream, and I couldn't doing any good.*
D: *Is it not?*
P: *No. No.*
D: *Right.* ***Oh I'll get that sorted out for you. No problem.***

(BNC/H5P/10–15)

(12) P: *If it helps my blood pressure I could live with the cold*
D: *[Yes. Oh yes.*
P: *fingers.] [(ha-ha)*
D: *Oh aye.]* ***Oh it's doing really nice.*** *And we'll see you in four weeks again.*
P: *That's fine.*
D: *And get it checked again June.*
P: *Okay.*
D: *Okay.*

(BNC/H4P/67–74)

(13) D: *Yes. Things from er data whenever can take ages and ages and ages to and you know doctors get sued every now and again, perish the thought, (ha-ha). Oh [(unclear)*
P: *Perish the thought but when]*
D: *you when you keep hearing reports in the medical journals about doctors being sued, and it can be several years after the event that the case comes to court.* ***Now it won't be that long in your case, but just goes to show how lengthy the whole thing can be.***
P: *Yea yeah yeah.*

(BNC/G5M/176–179)

(14) D: *Er and I hope everything goes as smoothly as possible.* ***If there are any medical reports to do, we'll get them done as soon as possible.***

(BNC/G5M/146–146)

(15) D: *What I want you to do is, just with you sitting just now, just lift your leg up like that, just hold it with your two hands. And just (.) do that. About twenty times a day. (.) Now your knee'll be sore, when you start doing it, because you, this muscle has to get strengthened up again. (.) And let the scar joined up. But as you keep doing that every day, it'll get less and less and less painful. And after about a week, there'll be no pain in it, and you'll be (.) doing it no bother at all. And that muscle'll grow over the top of that scar, and it'll get rid of all that for you Jim.*
P: *Okay.*
D: *Well that's so as you're, you're going to win after all.* ***You're going to win.***

(BNC/G46/23–25)

(16) P: *I mean it's quite serious.*
D: *Yes. Oh, yes. It is. Oh, aye, [(ha-ha).*
P: *(ha-ha)]*
D: *[(ha-ha)*
P: *off her head.]*
D: ***Families are strange. Families are***
P: *[(unclear)*
D: ***strange.]***
P: *Doctor.*
D: *(ha-ha)*

(BNC/H4W/174–183)

(17) D: *Now a teaspoonful in the morning. Teaspoonful at tea time. And two teaspoonful before you go to your bed. And that'll get the inside of that sorted out for a wee while again* ***young William****.*

(BNC/H4N/23–23)

Expectedly enough, these communicative practices do not occur in isolation; they overlap and combine with each other. In the following illustration (Example 18), after the diagnosis is revealed (*thyroid gland*), the doctor conveys his social closeness to the patient by a combination of informal expressions (e.g. *zombie*) with utterances calming the patient down and assuring her that everything will turn out well (*we'll get you sorted out, we'll keep things right for you*). All this is performed in a humorous and sharing ambience.

(18) D: *We'll get sorted out, but we'll check this first to make sure there isn't anything else, Ann. But it looks a fairly straightforward thing.*
P: *Mhm.*
D: *We'll get you sorted out, turn you into a human being again.*
P: *(ha-ha) (unclear) a zombie.*
D: *(unclear) instead of, instead of walking about like a zombie.*
P: *Aye, [a heavy*
D: *But er]*
P: *zombie. (ha-ha)*
D: *And right, er if you give me a phone about twelve on Thursday morning,*
P: *Mhm.*
D: *we should have that result back, be able to tell you what's happening. Okay?*
P: *Mhm.*
D: *We'll keep things right for you. Okay Ann?*
P: *(unclear). Thanks.*
D: *Right. Okay now.*
P: *Cheerio.*
D: *Cheerio just now.*

(BNC/G4B/99–115)

As is evident from Example 18, such instances often take place at the end of the consultation. Doctors seem to be fully aware of the importance of their patients feeling comfortable, and leaving the doctor's surgery without a bad taste in their mouth, with a glow of satisfaction, with a sense of security and a feeling of fellowship. These circumstances support positive treatment outcomes because patients are more likely to comply with their doctors' instructions (cf. Pendleton 38–39).

By contrast, it seems that during the diagnosis phase doctors tend to retain a certain degree of distance, and their verbal behavior can be characterized as off-hand and curt (Examples 19 & 20). They are reserved and formal, possibly with the aim of supporting their professional authority – which can, however, be face-threatening for patients.

(19) D: *Okay. You've got a nasty chest infection. (unclear) down here, the whole of the left side on the back.*

(BNC/GYC/46–46)

(20) D: *But the way things look to me, it looks as though your thyroid gland's beginning to slow down. (.) And this is why you're whole lot's*
P: *Mm.*

D: *all beginning to puff up.*
P: *Mhm.*
D: *And you're your particular just under here. I see the difference in you under there.*
P: *Mm.*
D: *And your, your whole face is a bit puffed, but mostly round about there.*

(BNC/G4B/87–93)

In addition, giving advice (Example 21), usually following the revelation of diagnosis, can also be assessed as a face-threatening act (cf. Heritage & Sefi 1992); it imposes the doctor's expertise on the client, and does not allow the patient to arrive at her own conclusions.[5] In the information-gathering phase, the patient is also exposed to a number of face-threatening acts. For example, the doctor may ask the patient to do something which could be embarrassing and/or uncomfortable for her (Example 22).

(21) D: *Okay. And what I suggest **we** do is seeing Georgina's here we send you through to see Georgina and she can, if she's got time, **we** briefly run through one or two types. See which suits you best.*

(BNC/G5W/81–81)

(22) D: *Okay, **can** you slip your shoe and sock off?*

(BNC/G5R/26–26)

In order to save both the positive and negative face of the patient, the doctor can employ a variety of techniques and mitigating devices. A large part of the present study demonstrates how the positive face of the patient can be saved, supported or maintained. (For some of the communicative strategies related to the way in which the negative face of the patient can be preserved, see Černý 2008.) The two examples above (22 & 23) illustrate just two such techniques: (i) the use of inclusive 'we' (cf. Henzl 1989), and (ii) the use of the modal verb 'can' to soften the impact of the directive.

5 Qualitative Perspective: Positive Politeness Strategies Manifested by Patients

Compared to the relative distribution of doctor-initiated positive politeness strategies, the figures for patient-initiated positive politeness strategies signal both similarities and differences (see Table 2).

As far as the classification of strategies is concerned, both participants give significant preference to a communicative mechanism labelled 'claim common ground', with even stronger stress placed on the part of the patient (D – 63% : P – 80%). A discrepancy can be seen in the use of the other two mechanisms: 'convey that S and H are cooperators' and 'fulfil H's want'. Whereas doctors prefer the former, patients give preference to the latter. According to Brown & Levinson (1987), this strategy ('fulfil H's want') is reflected in situations in which the S wants to satisfy the H's positive-face want by actually satisfying some of H's wants. "Hence we have the classic positive-politeness action of gift-giving,

not only tangible gifts (…), but human-relations wants such as those illustrated in many of the outputs considered above – the wants to be liked, admired, cared about, understood, listened to, and so on" (Brown & Levinson 129). Transferred into a more specific medical environment, patients not only do what their doctors want them to do, but often express respect, admiration, etc. (Example 23).

(23) P: *I've got the post from the hospital to get*
D: *[(unclear)*
P: *and medication from them, Doctor.]* ***Ah, God, I don't know how you take your job.***[6]

(BNC/H4W/18–20)

Regarding the distribution throughout the medical interview, the doctor and the patient follow the same order of 'phase productivity': the most numerous section is the treatment phase, followed by the information-gathering phase, while the least numerous is the phase of diagnosis. The most interesting finding is that the relative number of strategies initiated in the treatment phase is identical for doctors and patients (60%). This confirms that the end of the consultation is the most positively polite section of the medical encounter. It is a section of reciprocity, intimacy, and empathy (Example 24).

(24) D: *Nothing to worry about with that. (unclear) (.), there we are now.*
P: *I shall survive again then.*
D: *You are going to live for a wee while yet, going to live for a wee while yet. Yes. Oh aye oh.*
P: *((ha-ha))*
D: *If you've got anything funny like that, you get it checked.*
P: *Aye, right away.*
D: *Don't, don't ignore it.*
P: *Well I think you can go home now cos I was the last.*
D: *Och. You think so? I would, I wouldn't bet on it. I wouldn't bet on it.*
P: *(ha-ha)*
D: *[Right,*
P: *Thanks.]*
D: *okay Cathy, cheerio now.*

(BNC/G4E/45–57)

The positive talk of patients takes a range of forms. Patients ask their doctors quite personal questions concerning their families (Example 25) or the way they feel (Example 26 & 27). Sometimes they tease doctors, thus showing friendliness (Example 28). They may initiate a joking atmosphere, resulting in laughter (Example 29), or make social (non-medical) and informal remarks (Example 30 & 31).

(25) P: ***What about your own family?*** *You still got them?*
D: *Yeah. Oh well. Yeah, they're still*
P: *Still keeping you*

D: *still keeping me out of mischief.*
P: *[Still keeping*
D: *Still keeping me out of mischief.] (ha-ha)*

(BNC/H5V/132–137)

(26) P: ***How are you keeping yourself, Doctor?***
D: *Me? Fine.*

(BNC/H5A/128–129)

(27) P: *Okay then.*
D: *Right. Okay Alison.*
P: *Thanks a lot.*
D: *Right. Cheerio now.*
P: *Bye.* ***Are you alright yourself?***
D: *Yeah. Yeah. It's no no problem.*
P: *(ha-ha) (unclear) it's just typical isn't it?*
D: *That's it.*

(BNC/H59/83–90)

(28) D: *Good evening*
P: *Hello.*
D: *Mary.*
P: ***She said when I came in, there's only two in front of you. And you know I've been sitting an hour.***
D: *(ha-ha)*

(BNC/H4F/1–5)

(29) D: *This is old age coming.*
P: *Old age doesn't come itself so they say.*
D: ***((ha-ha))***
P: *Och well.*
D: ***(ha-ha)***
P: *Och well, that's it.*
D: ***((ha-ha))*** *If that's all, if that's all we get for getting old, w w we'll do (unclear).*
P: *That's it. Well that's fine, we'll do.*

(BNC/G4D/134–141)

(30) D: *(ha-ha)*
P: ***Cos when you smoke you kept your money for your fags, but if you don't smoke you don't need to keep it.***
D: *(ha-ha)*
P: *[(ha-ha)*

D: *((ha-ha))] I thought you'd have been buying an oil well or something like that.*
P: *I know, I didn't realize, (unclear).* ***My two brothers are off on holiday now for ten days.***
D: *Aye.*

(BNC/H53/11–17)

(31) P: ***It was bloody painful. If you excuse the French.***
D: *That's it.*

(BNC/H50/52–53)

Similarly to doctors, also the patient-initiated positive politeness strategies form a number of varied combinations. In Example 32, first the doctor and the patient give information regarding the treatment. Then the patient proceeds with a humorous remark (*well I didn't have to wait too long for you today*), resulting in mutual laughter and elaboration of the remark. After that the doctor plans to close down the interview (*away and look after yourself*), but the patient continues with a series of social complaints which draw the doctor back into the discussion, sharing his own perspective. Only then does the active patient shift the topic of the interview back to treatment issues (*so, four weeks?*), and the doctor finally closes the encounter.

(32) D: *Now I want to see you in four weeks again.*
P: *Oh you want to see me in four weeks?*
D: *Mhm.*
P: *How long did you give me my certificate for?*
D: *Thirteen weeks.*
P: *Thirteen weeks? But er you want to see me in four weeks to see about that?*
D: *Thirteen weeks. But I want you to come back in four weeks. Mhm. (.) I want you back in four weeks.*
P: *Well I didn't have to wait too long for you today.*
D: *(ha-ha) It's a change.*
P: *((ha-ha)) Is it? I know I keep saying to*
D: *[It's a change.*
P: *myself, you know] er cos I'm saying I said, how many's that that's been into that doctor? And a new doctor I was talking to, I says, three went in (unclear) I says, ((ha-ha)) Hope they're all going into (unclear), doctor.*
D: *[(ha-ha)*
P: *((ha-ha))]*
D: *Away and look after yourself.*
P: *I think it's, I think it's er I'm just getting old, it doesn't happen (unclear). See, I'm used to doing everything myself.*
D: *Mhm.*
P: *I've always had to do everything.*
D: *Aye.*

P: *And wheelbarrow, (unclear), you know and see now. I keep saying, (unclear) You used to (unclear) your children, but they don't do nothing for you now, don't they*
D: *[Not much.*
P: *not?]*
D: *I wouldn't hold (unclear) your breath waiting for them nowadays.*
P: *So, four weeks?*
D: *Right, see you four weeks.*
P: *Er right, aye.*
D: *Right Agnes.*
P: *Right. Thanks.*
D: *Cheerio now.*

(BNC/G45/128–156)

Under certain circumstances the communicative behaviour of the above patient could be considered not face-addressing but face-threatening, as it imposes on the doctor the patient's ideas about how the consultation should proceed. However, the doctor does not seem to be offended; he empathizes with the patient, and lets her disclose what she wants to share. In general, patients very rarely carry out face-threatening acts (cf. Fisher 1983). In spite of this, there are a few instances of FTAs in the material under scrutiny. Usually they take place during a follow-up when the patient complains that her health condition is not better, thus questioning the doctor's professional reputation (Example 33), or she even offers her own version of post-diagnostic accounts (Example 34), and in this way she challenges the doctor's treatment assessments and recommendations (cf. Heath 1992).

(33) D: *Well now. What can I do for you today?*
P: ***Oh it's just it's not getting any better.***
D: *You're still having trouble?*

(BNC/H4E/7–9)

(34) P: ***See these tablets you gave me. They're no use.*** *I prefer to keep*
D: *[Are they not?*
P: *with the (unclear)]*
D: *[Mhm.*
P: *that I've got.]*
D: *Right.*
P: ***Because you gave me ten milligrams and the five's not very strong. But I'm not very well with them and I just think they're terrible.***

(BNC/H51/51–57)

The last point which I would like to mention here and which is, naturally, related to the phenomenon of politeness as manifested in doctor–patient communication concerns the participants' orientations to conversation and politeness maxims. In Adegbite & Odebunmi's view: "The maxim of quality is almost always obeyed in doctor–patient

interaction because participants recognize the need for truth in the resolution of medical problems. However, the other maxims of quantity, relation and manner are sometimes flouted in the course of expression of sentiments and emotional feelings and avoidance of unpleasant consequences" (510). Politeness maxims are parallelly adhered to for salutary purposes (Adegbite & Odebunmi 511–513). Since this is exactly what can be found in my material, I shall merely refer to this source, without adding any detailed comments.

6 Concluding Remarks

Taking into consideration what has been said in the last paragraph of the preceding section, it could be argued that so much that is relevant and related to the topic of politeness is not given direct attention within the scope of the present paper. This is obviously true, but in my view, to provide a complete examination of such a complex and multivalent phenomenon would be impossible anyway. Despite all of these acknowledged deficiencies, I hope that my research has shed light on several (albeit limited) aspects of doctor–patient interaction with respect to the politeness principle.

The findings indicate that both dialogue participants (the doctor and the patient) employ positive politeness mechanisms quite frequently, throughout the medical interview, and of all selected types. The quantitative analysis, supplemented with qualitative interpretation, shows that the most productive category of positive politeness is 'claiming common ground' and the phase which witnesses the most frequent utilization of these strategies is the treatment phase. In addition, it can be stated that to address the positive face wants of their patients, doctors initiate a series of varied positively polite strategies, enabling them to convey, among other things, social closeness, empathy and understanding to their clients. The positive talk of patients also takes a range of diverse forms. Patients often manifest friendliness, tease their doctors, joke, laugh, and initiate social talk. Individual strategies are combined, and contribute to a trustful and sharing atmosphere between the doctor and the patient. At the same time, however, it needs to be remarked that both interactants initiate face-threatening acts, though patients do so only rarely. On the other hand, they also use a variety of techniques and mitigating devices employed in order to save 'face'. In addition, both participants orient themselves towards conversation and politeness maxims, usually following the maxim of quality, from time to time flouting the remaining conversation maxim, and parallelly adhering to politeness maxims for salutary purposes. Importantly, the section of diagnosis, compared to the final part of the consultation, is much more formal, with the participants rather reserved and keeping their distance.

Clearly, the medical consultation is a dynamic discourse type which defies absolute and exhaustive conclusions. It is especially for this reason that I do not rely exclusively on my own findings, but often refer to other sources. On the other hand, I believe I have brought enough evidence to support the standpoint that recent social changes have modified the traditional model of the doctor–patient relationship and prepared ground for reduction of hierarchies and redefinition of roles in favour of the patient.

Notes

[1] In general, I understand empathy as an "emotional experience between an observer and a subject in which the observer, based on visual and auditory cues, identifies and transiently experiences the subject's emotional state. To be perceived as empathic, the observer must convey this understanding back to the subject" (Hirsch 2009).

[2] Besides calculating absolute and relative numbers, I also use more sophisticated approaches, namely correlation and the F-test. Correlation is a measure of the relation between two or more variables. Correlation coefficients (I employ Pearson) can range from -1.00 to +1.00. The value of the former one represents a perfect negative correlation, the value of the latter represents a perfect positive correlation. The F-test calculates statistical evidence whether two samples have the same standard deviation with specified confidence level. Samples may be of different sizes. In lay terms, it proves whether two samples differ to such an extent that this differentiation is worth studying.

[3] HRT = hormone replacement therapy.

[4] Brown & Levinson (1987) distinguish the following fifteen positive politeness sub-strategies: within 'claim common ground': (i) notice, attend to H, (ii) exaggerate, (iii) intensify interest to H, (iv) use in-group identity markers, (v) seek agreement, (vi) avoid disagreement, (vii) presuppose/raise/assert common ground, (viii) joke; within 'convey that S and H are cooperators' we have (ix) assert or presuppose S's knowledge of and concern for H's wants, (x) offer, promise, (xi) be optimistic, (xii) include both S and H in the activity, (xiii) give (or ask for) reasons, (xiv) assume or assert reciprocity; within 'fulfil H's want for some X' (xv) give gifts to H.

[5] On face-threatening acts in nursing discourse, see Valdmanová (2008), in which she proposes similar findings for nurse–patient interaction.

[6] This instance could be assessed as a face-flattering act (see Kerbrat–Orecchioni 1997).

Appendix

Below are results of the F-test, containing calculations relevant for the quantitative section of the present study. The asterisk indicates when the results are of particular significance.

F / Participant	*Cooperator*	*Fulfil want*
Common ground	0.0002*	0.9668
Cooperator		0.0016*

F / Phase	*Cooperator*	*Fulfil want*
Common ground	3E-05*	0.0191*
Cooperator		0.1375

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