

*“Let’s Examine Your Abdominal Region”:
A Conversation Analytical Study Of Doctor-Patient
Communication*

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Abstract

*I*n medical care, lack of communication is such a crucial subject which may result in unintended but severe consequences. Employing the theoretical framework proposed by Brown and Levinson (1987), this study was conducted to find out whether or not there are differences in the use and number of the politeness strategies employed in the doctor-patient communication. The effect of three contextual variables, that is, power, age and gender were also studied to contribute to our understanding of the concept of verbal politeness. Through observation and audio recordings of 31 patients (16 female and 15 male) who are categorized as younger or older than the doctor, one doctor’s conversation was analyzed within the context of five politeness strategies and politeness/solidarity criterion in a radio-diagnostic clinic. The study affirms that the doctor uses ‘Bald on Record’ strategy with both male and female patients. However, in the category of female older patients ‘Negative Politeness’ are recorded while Positive Politeness’ strategies are observed with female younger patients. As a whole, employed strategies from most direct to indirect ranged in parallel with the factors of age and gender. Moreover, the results have shown that except for the group of younger females, the doctor prefers an attitude of solidarity with all patients.

Keywords: Linguistic Politeness, Doctor-Patient Communication, Conversation Analysis

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Introduction

*E*veryday, more complicated and sophisticated technological devices are introduced to the medical world; however, it should not be forgotten that seemingly the first and simplest way to diagnose an illness is the sole interaction between a doctor and a patient. The most important feature of language is communication especially when interlocutors are doctors and patients, it makes more sense. Patients because of their illnesses experience a mental burden and they need professional help to relieve themselves physically and psychologically. Type of behavior which is expected from doctors is ‘behaving well’, in other words, ‘politeness’. As Eelen (2001) suggests, the concept of politeness recalls Brown and Levinson’s (1987) politeness theory which has been adapted in many studies (e.g., Al-Momani, 2009; Chen, He & Hu, 2013; Nevala, 2004; Sirota, 2004; Zibande, 2005). Politeness strategies, in parallel with the factors of power, age, and gender, label an utterance as (im)polite (Brown & Levinson, 1987). Moreover, many languages make a distinction between ‘singular you’ *tu* (T) and a ‘plural you’ *vous* (V). However, the social conditions require the usage of T form in ‘familiar’ and the V form in the ‘polite’ situations (Wardhaugh, 2006). Many factors

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such as age, gender, social distance, power, or cultural issues are considered to decide either is used.

Effective verbal communication among all members of the health care is the foremost step of the doctor-patient relationship and doctors and patients should recognize their responsibility to each other in order to achieve an ideal health care delivery. Burke (2008) carried out a research on trainee doctors' experiences of doctor-patient relationship to investigate trainees' perceptions of not only doctor-patient interaction but also the nature of that communication and how they learn to develop relationships with patients. She added that the relationship has been described as one of the exclusive and puzzling forms of human communication which requires the power of both interlocutors minded. The trainee doctors stated that they can improve their communication skills through personal experience and by observing senior medical students' treatments with patients (Burke, 2008).

Another study which enlightens the importance of doctor-patient communication was conducted by Hall, Roter, and Rand (1981). They attempted to find whether there is an association between the patterns of doctor-patient communication and the client's contentment and appointment-keeping. Findings indicate that the patient's contentment with the medical visit is related to the ratings of the physician's communication, and the doctor's behaving in an angry or anxious way affects the patient's return for subsequent visits.

Ijas (2008) in the review of *The Dynamic Consultation: A Discourse Analytical Study of Doctor-Patient Communication* declares that doctors' employing more humanistic voice, assisting patients' storytelling and asking questions unrelated to the patient's health, create empathy with the patient. Neeman et al. (2012) is another study which emphasizes the crucial effect of doctor-patient communication on patient satisfaction and establishing confidence between client and doctors. The findings display that facilitated communication results in patients' highly satisfaction and more actively involved in their own healing process. Davis (2010) also affirms that doctors may express empathy and open friendly dialogues with patients to achieve their satisfaction and success in medical care.



Yin, Hsu, Kuo and Huang (2013) conducted a research in pediatric clinics in Taiwan and investigated the communicative interaction behaviors of doctors, patients and patients' parents. Thirty outpatients and six doctors participated in the study. Results of the analysis indicated that the most employed politeness strategies used in pediatrics were Bald-on-Record. Moreover, doctors adapted a dominant role in communication process which demonstrated an asymmetric power balance between doctors and patients. Yin et al. (2013) argued that this asymmetric relationship may result from Chinese culture in which doctors, lawyers and teachers hold professional power which comes from respect for their expertise.

The significance of the doctor-patient communication comes out at the end of every study. Various positive aspects of this type of communication, for example, showing sympathy or asking non-medical questions result in favorable consequences such as patient's both physical and psychological comfort, patient's adherence to treatment and even recovery from illnesses. To figure out the doctor-patient communication in a private hospital in which interlocutors are Turkish Muslims, this study addresses the following question: Does the patient's age and gender affect the politeness strategies employed by the doctor?

Methodology

The present study uses a methodology that considers the patients' gender, age and some parts of their conversation with doctor and employs the written account of observation of the patients. Observation sheet is designed in a way that it divides patients to groups of males and females who are younger or older than the doctor. Moreover, after asking for the required consent from both groups, the doctor and patients' conversation was recorded and transcribed. Some parts of the conversation was noted down to ease the transcription phase in terms of distinguishing which voice belongs to which patient (i.e., older or younger). As the observer wished to keep the patients' privacy, she preferred not to ask their name. Then, according to Brown and Levinson's politeness theory (1987), the doctor's employed strategies are evaluated. Also, the researcher asked some questions to doctor at the end of the research to identify the ideas of doctor about doctor-patient communication. The participants in this study included 31 (15male with 8 younger and 7 older, and 16 female with 8 younger and 8 older) patients in Radiology

clinic and the doctor has been practicing about 22 years as a specialist of Radiology Diagnostic.

The reasons for choosing the radiology doctor and patients as the population are: (1) as the radiological clinic is a diagnostic ward, this branch deals with a higher number of patients because other clinics ask some of their patients to refer to this clinic for diagnostic purposes. Therefore, the number of observations increases; and (2) as Bazzocci (2012) suggests speech has a vital role in a radiologist’s profession; moreover, the politeness subject is a very sensitive area, and there would be communication in detail to find the relationship between doctor and patient such as addressing and sharing talks about daily life, so again radiology ward would be a better place to analyze this relationship in medical area.

Results

Employed Politeness Strategies

In Figure 1, politeness strategies have been analyzed through four categories according to ages and genders of patients. The numbers show how many times each strategy was used.

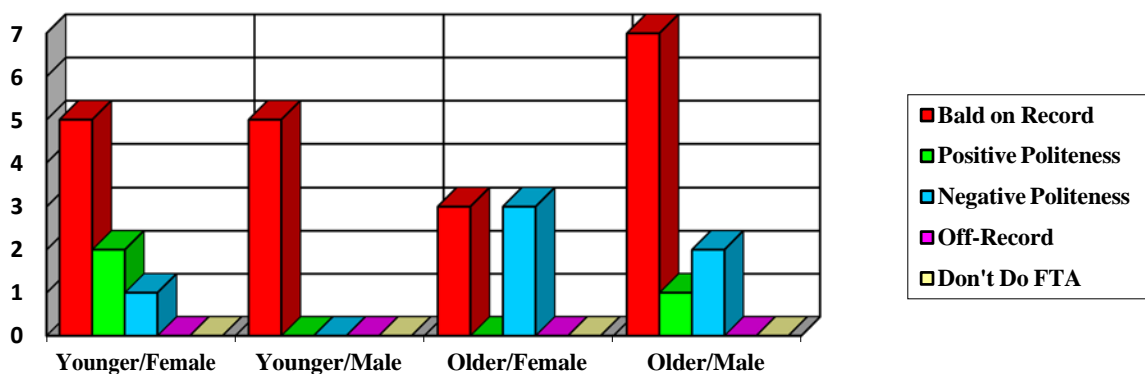


Figure 1. Employed politeness strategies. This figure illustrates the strategies employed to patients according to their age and gender.

It is clear from the figure that ‘Bald on Record’ is the most preferred strategy. For example, the doctor said to a twenty-nine year old, female patient “hold your breath a while!”, similarly, he told to a forty- six year old male patient “take a deep breath, hold”. These instances show that the patients are younger than doctor and the gender

was ineffective as the number of ‘Bald on Record’ is the same for both genders so the approach of doctor is direct communication whether it is female or male. Unlikely, while speaking to older-female patients doctor rarely prefers ‘Bald on Record’. On the other hand, the highest value of ‘Bold-on-Record’ is displayed in male patients, who are older than doctor; it is surprising since talking to old people requires respect and indirect speech but here, doctor minimizes the distance and uses direct sentences.

The other strategy is ‘Positive Politeness’ which is mostly used in female patients, who are younger than doctor. Using inclusive forms such as “we” or “let’s” indicates positive politeness (Morand, 2000) which is much face saving than ‘Bold on Record’. For example, the doctor told to a twenty-five year old female (pregnant) patient “we’re going to apply three-stepped diagnose procedure to baby to...” although it is only the doctor who will make 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 preferred. In older/female category which as expected includes the highest frequency of ‘Negative Politeness’, the doctor did not use ‘Positive Politeness’ at all.

The doctor communicates with female and male patients who are older than him, with most respect and distance so frequency of using “Please” or “Could/Can you” expressions prove the higher frequencies of employing ‘Negative Politeness’. In the categories which patients are younger than the doctor, the patients of the same gender are treated with no and patients of the opposite gender are displayed with the lowest frequency of ‘Negative Politeness’. It might be asserted that as the patients are younger than the doctor so he observes no need to use distant manners.

The zero frequency of ‘Off-Record’ and ‘Don’t do the FTAs’ represents a normal and expected distribution since the doctor-patient communication requires a kind of transparent relationship and patients should share their problems other than using implications or signs and the doctor should feel the comfort of asking for information easily with his patients.

Politeness and Solidarity

In Figure 2, solidarity and politeness criterion with four categories are analyzed while the age and the gender of patients are variables of the study.

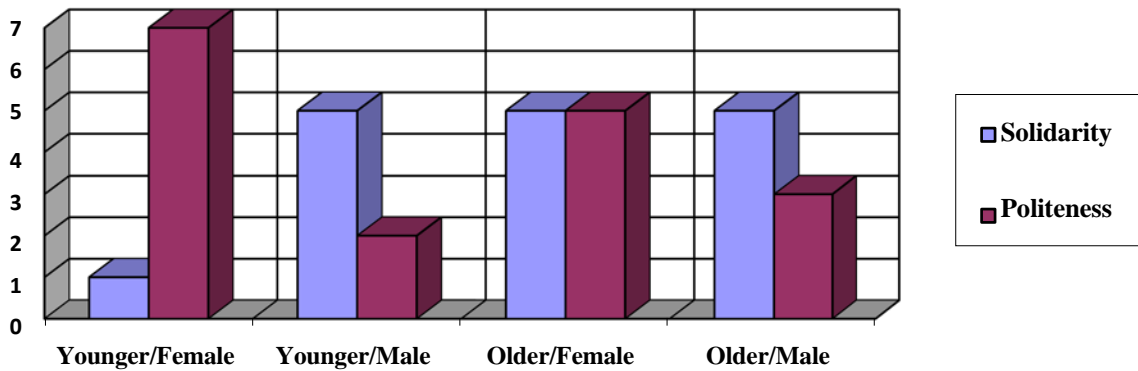


Figure 2. Solidarity and politeness criterion. This figure illustrates the frequency of solidarity and politeness criterion applied to patients according to their age and gender.

In female patients, who are younger than the doctor, the least solidarity has been preferred but the most polite manners have been used. For example, while doctor was asking a twenty-nine year old female patient “Have you newly had a surgery?”, he used singular ‘you’ which means sincerity or solidarity; however, it happened only once. On the other hand, the employment of addressing phrases such as “yenge hanım, yenge” (‘brother’s wife’ and the addressing form of ‘Mrs.’) and plural ‘you’ might display politeness.

In male patients, who are younger than doctor, the situation is vice versa since the doctor used mostly singular ‘you’ like “Just slip off your shirt”. It is clearly based on that both interlocutors are of the same gender and the doctor feels no need to set a distance between himself and the patient; they benefit from some kind of men-talk with more sincere behaviors. Thus, related to the higher excess of solidarity, politeness is less observed in terms of above mentioned reasons.

In female patients who are older than the doctor, both solidarity and politeness are balanced. While the doctor’s uttering singular ‘you’ scales up the solidarity as a means of sincerity, applying of addressing phrases like “teyzem, teyze, anneciğim”(‘My aunt’, ‘Aunt’, ‘My dear mother’) raises politeness.

In male patients, who are older than doctor, the doctor uses mostly singular ‘you’. For example, the doctor says to a fifty-eight year old male patient “Now, you clean your tummy...” thus, the distance between doctor and patient minimizes as a more sincere talk. On the other hand, with addressing phrases like “hacı abi, amca” (‘older brother’,

‘uncle’), the level of politeness arises since the doctor displays his respect to patient but again because of a kind of men-talk, solidarity is higher than politeness. As a whole in this figure, the most marked result is doctor’s neglecting age and gender with all groups except for younger/female in which he behaves politely and on the other hand prefers solidarity with the same frequency in other 3 categories.

Results of the Interview

After the observation section of the study, an interview was arranged with the doctor to enrich data gathered through observation. The doctor’s most determining factor for addressing patients was the importance of age and then gender since having respect for old people regardless of the gender was the foremost factor for addressing. Moreover, the doctor did not mention gender as a very differentiating factor. He states that patient’s gender especially of young ones might be determinant; however, as in radio diagnostic clinic patients’ private problems are issued, it is important to establish a friendly communication. Finally, the doctor’s friendly approach towards older patients was wondered. He stated that as the older patients who suffer mostly from severe illnesses felt usually shier than the younger, so showing solidarity and making them feel relaxed is of high crucial importance. The doctor also considers the patients as the members of his family like mother and father so he shows sympathy for old patients. Besides, the doctor believes his friendly attitude decreases the asymmetrical power relations between him and patient which in turn reassures the required communication opportunities for patients.

Discussion

With the research question which attempted to find whether or not the patient’s age and gender affect the politeness strategies employed by the doctors, the findings revealed that the patient’s age and gender affect the doctor- patient communication.

Considering the younger/female patients, all of the collected data has proved 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’ that the doctor employed. Also, the ‘Negative Politeness’ strategy employed with this group includes the third place among all four categories which means a low

frequency. Since the patients are younger than the doctor, the strategies representing distance are not employed.

Besides, from an overall perspective the doctor's communication with male patients whether younger or older is almost always direct. It can be understood that when a younger/male patient is diagnosed, the doctor (also male) has used less distant attitude in other words, prefers direct utterances. However, it was surprising that the highest number of 'Bald on Record' is in older/male patients since it was expected that we should not use so direct sentences but polite manners with old people. On the other hand, considering the employment of 'Positive Politeness' and 'Negative Politeness' with the older/male group, the importance of age is inferred again. Moreover, the doctor, in the interview had mentioned about the older/male patients feeling more embarrassed. This suggests the doctor's establishing a balance between the age and gender factors.

The doctor is also balanced in terms of findings with older/female patients since 'Bald on Record' and 'Negative Politeness' strategies possess the same numbers. Again, the doctor has tried to show both respect and establish sympathy and solidarity with this group.

It can be concluded that in this study, the age and gender are important factors in doctor-patient communication. Cultural values are of crucial importance in determining the employed strategy. For example in both female and male older groups, more 'Negative Politeness' strategies (i.e., 5) have been employed in comparing with younger group of both genders (i.e., 1). In Turkish culture, old people are respected so the direct speech with imperative sentences which indicates the 'Bold-on-Record' strategy is not used but more polite behaviors are preferred. Also, 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 respected more which displays another aspect of cultural values. As a whole, the groups to which the most direct (impolite) to most indirect (polite) strategies have been employed are ranked as follows: 1) younger/male, 2) younger/female, 3) older/male, and 4) older/female.

The cultural preservation can be depicted also in the Figure 2. Both female groups (both younger & older) are treated with less solidarity (i.e., 6) and more politeness frequencies

(i.e., 12) in comparing with male groups (both younger & older) who are treated with more solidarity (i.e., 10) and less politeness frequencies (i.e., 5).

This study reveals the fact that the doctor-patient communication has its own norms but culture-oriented. This study has been done in an Islamic country; the same results might not have been reached at if the study were realized in a Western country which has different cultural factors. Stewart, McWhinney, and Buck (1979) described the doctor-patient relationship “as reflected by the doctor’s knowledge of the patient’s problems, psychological and social as well as physical”; however, doctor’s awareness did not “significantly affect the patient’s satisfaction” (p.77). In power-related communication, although doctors possess a higher status, in Islamic countries doctors respect the patients and behave in a polite manner. Faiz Khan (2008) emphasizes the importance of religion and doctrines of Qur’an in doctor-patient interactions.

Another important point is the fact that medical schools should place importance on communication skills education. It is known that some doctors’ practice are refused by patients only because of a lack of healthy communication between them and doctors even if the doctor possesses a highly appreciated medical knowledge, so a cultural-medical awareness training might be placed in medical education. As Verlinde, Laender, Maesschalck, Deveugele, and Willems (2012) 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 (p.1). In other words, an education program which includes both medical and cultural norms might be presented to medical students in terms of doctor-patient communication. Therefore, the better they communicate with patients, the better results of medical treatments will be reached at.

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