

CONFRONTATION AND POLITENESS STRATEGIES IN PHYSICIAN-PATIENT INTERACTIONS

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Abstract—The therapeutic success of physician-patient interactions depends in large part on how physicians interpret and respond to patients' implicit and explicit messages. Using a hypothetical vignette, in which a patient refuses to comply with a recommended therapeutic regimen, we found that first-year medical students with no classroom training in medical interviewing implicitly recognized that the situation called for face preserving or polite linguistic behavior. Ninety percent of them used culturally sanctioned politeness forms to repair the conversational breakdown depicted in the vignette. They responded to this clinical scenario, however, with linguistic behaviors borrowed from their everyday interactions, some of which were culturally appropriate, but not necessarily therapeutic. We suggest that students can learn to adapt their culturally appropriate behaviors and engage in therapeutic communication as physicians if they are given the necessary conceptual tools. We discuss how Brown and Levinson's theories of politeness and strategic language usage can (1) provide a framework for interpreting communication in general and physician-patient interaction in particular, (2) illuminate some of the problems inherent in doctor-patient encounters, and (3) be used prescriptively for teaching students and health professionals how to avoid some communication difficulties.

Medical schools are under increasing pressure to graduate students who have acquired a measurable degree of communicative, as well as technical competence [1]. In the past decade, researchers have presented compelling evidence that good doctor-patient communication is essential for increasing patient satisfaction and compliance, improving physiologic responses to treatment and decreasing the number of malpractice suits [1-4]. The American Board of Internal Medicine has proposed that residency certification be contingent upon residents' attainment of effective interpersonal skills, including the ability to engage in clear, mutually satisfactory communication with patients [5]. In response, medical educators have been developing programs designed to enhance the communication skills of their students to make these skills commensurate with their technical expertise. Typically, educators have designed and evaluated these programs by adopting an assortment of concepts, techniques and instruments from the fields of counseling and clinical psychology [4-7]. Their aim has been to equip students with a checklist of rapport-building and empathic interviewing techniques. For example, students are trained to use open-ended questions at the beginning of interviews, facilitations, reflections and probes to elicit information, and empathy in emotional situations. A program's success is often measured by students' abilities to identify and use preferred forms in test situations (e.g. [8, 9]). One of the difficulties with this kind of technique building approach is that it does not give students the kind of conceptual framework (e.g. [10]) they need in order to continue developing their interactive skills when they are no longer supervised. If in the process of becoming doctors, students are going to be asked to modify their existing patterns of interpersonal behavior, then first they need to understand what their current modes of interaction accomplish and why

they might need to be changed. As Brodsky and Richman [10] noted, "students need to develop new templates for communication and new conceptual categories with which to process and retain the information obtained".

This study explored how the descriptive theories of politeness and strategic language usage [11] can provide a framework for interpreting communication in general and physician-patient interaction in particular. It also illustrates how the concepts of 'face' and 'politeness' can help to illuminate some of the problems inherent in doctor-patient encounters and be used prescriptively for teaching students and health professionals how to avoid some communication difficulties. According to the theory of strategic language usage [11], in successful interactions, people achieve their goals through negotiation without violating one another's desires (a) not to be imposed upon and (b) to be liked and admired. Acts of imposition and criticism are known as *face threatening acts* and can lead to conversational breakdown unless the violations of face they represent are redressed in some way. In most instances, redress and conversational repair take the form of some kind of face preserving or polite linguistic gesture.

In therapeutic encounters, where physicians and patients negotiate about the validity and severity of patients' illnesses, as well as lifestyle changes, there are frequent opportunities for patients to interpret what their physicians say as face threatening. On the one hand, if doctors diagnose patients as being ill, then they legitimize their claims to patienthood. On the other hand, doctors threaten patient 'face' when conveying bad news. Furthermore, when physicians prescribe treatment regimens, they may limit patients' lifestyle choices and so, by definition, violate face.

Cross-cultural research suggests that people tend to avoid talking about physical inadequacy, illness and disease [12]. When these matters do become the

topics of conversation, they are likely to produce anxiety and trigger defensive verbal behaviors which can lead to conversational breakdown. Where knowledge is unequal, as is often the case in the context of physician-patient encounters when patients do not know much about their medical problems, patients' anxieties about their illnesses may be exacerbated by their feelings of dependency. Because all of these factors interfere with a clear exchange of meaning and mutual comprehension, physicians need to acquire interpersonal skills that "translate respect for their patients into a capacity to engage them in conversation as equals" [12]. The politeness strategies described by Brown and Levinson [11] represent culturally appropriate ways of accomplishing this translation. Their use acknowledges patients' feelings and also accomplishes conversational repair when necessary. Using negative politeness, which is most closely associated with lay notions of polite behavior, individuals can convey the message that they recognize and respect others' desires not to have their freedom of action curtailed. When individuals employ positive politeness strategies, they assert their respect for and acceptance of others by treating them as in-group co-members [11].

METHODOLOGY

As part of an ongoing project to evaluate the effectiveness of the University of Michigan Medical School's Introduction to Medical Interviewing and History-Taking course, students complete a Medical Communication Index and a Medical Helping Relationship Inventory prior to and following their course participation [7, 9]. The Medical Communication Index (MCI), which was developed at the University of Michigan, consists of three distinct written patient statements to which students are asked to respond in one or two written sentences. The data for this study consists of responses elicited by one component of the MCI portion of the 1986 course pre-test. First-year students ($n = 172$) participated in this evaluation by responding as if they were the patient's physician to the hypothetical patient statement, "You can talk to me all you want, but I will *not* follow that diet! I have had it with all of you telling me how to organize my life!"

This particular vignette was included in our pre-test not because we consider it a routine example of what occurs in all doctor-patient interactions, but because it illustrates to students that physicians as well as patients must find ways of coping with the anxieties and defenses triggered by illness. It is likely that all physicians encounter this type of situation during their professional careers. Physicians who can understand and weather patients' initial anger and demands and show them concern and respect are better able to help their patients than those who cannot [13]. Because medical students and doctors find little help in the literature about dealing effectively with problems that undermine good physician-patient interactions [14], educators need to find ways of exposing students to a variety of doctor-patient encounters, including those that are problematic. One of the most effective ways of giving

them this practice is to use illustrative hypothetical vignettes [15]. Each student's response to the hypothetical scenario was classified into one of seven categories. These included two types of positive politeness: (1) assert reciprocity and (2) give reasons, and three types of negative politeness: (3) apologize, (4) impersonalize, and (5) question or hedge. Category 6, empathic response, is a counseling psychology technique in which individuals respond to both the content of what another individual says, as well as how that individual feels about the content. Medical students are currently being trained in many programs to use this type of response in difficult or emotionally charged encounters. Category 7, bald, on record statement, represents a type of unmitigated, direct, clear, concise and potentially face threatening response. Definitions and an illustrative example of each of the categories are provided in Table 1.

RESULTS

Six student responses were excluded from our analysis because they were not written as if they might be spoken. Among the remaining 166 responses, 90% represented some type of *positive* or *negative politeness*, 5% were *bald on record statements*, and 5% were *empathic responses*. There were no differences in the patterns of response for males and females.

Among the many forms that negative politeness strategies can take, students chose to use those of *apologizing* or *admitting the impingement* (35.5%), *impersonalizing* (14%), and *questioning* (26.5%). The two positive politeness strategies used were *claiming goal reflexivity* (3%) and *giving reasons* (11%).

DISCUSSION

Overall, students with no classroom training in medical interviewing implicitly recognized that the situation called for face preserving linguistic strategies. They used a variety of culturally sanctioned politeness forms to repair the potential breakdown in communication depicted in our vignette. But they responded to this clinical situation with linguistic behaviors borrowed from their everyday interactions, some of which were culturally appropriate, but not necessarily therapeutic. By gaining an understanding of their interaction strategies, however, it is likely that these students can learn to adapt their culturally appropriate behaviors and engage in therapeutic communication as physicians. We suggest that by becoming familiar with politeness and other theories borrowed from the disciplines of anthropology and linguistics, students might be able to achieve some of the major goals of their medical education: to understand, evaluate and modify their existing patterns of learning and interacting and synthesize new behaviors with old ones [10].

Doctor-patient relationships are difficult in part because they are developed and sustained in the peculiar context of medical interviews. In most other contexts, individuals are able to choose the 'face' they present to others, and conversational interaction is devoted to mutual face maintenance. In the medical

Table 1. Percentage of medical student ($n = 166$) response strategies elicited by the hypothetical patient statement: "You can talk to me all you want, but I will not follow that diet! I have had it with all of you telling me how to organize my life!"

Strategy type	Strategy description	%	Example
Negative politeness no. 1: Apologize Two variations: (A) Admit the impingement (B) Indicate reluctance	Students redress face by communicating regret or reluctance to prescribe treatment regimens that limit patients' lifestyle choices.	35.5	I understand this is asking a lot of you, but you must understand this diet is essential for your health. I wouldn't ask you to do it if I knew it wasn't important. I'm not going to pretend that following this diet is going to be easy—for you—it's going to be a real pain. Really, I'm not telling you how to run your life I'm only suggesting a way to make your health better because I'm concerned about you as my patient.
Negative politeness no. 2: Question, hedge	By using questions or hedges, students demonstrate their reluctance to coerce patients into making changes.	26.5	Do you understand why we prescribed that diet for you?
Negative politeness no. 3: Impersonalize	Students dissociate themselves from their face threatening acts by implying that the treatment regimen was suggested by some other authority.	14	My suggestions are simply derived from my medical training and practical experience. Both have shown me that the diet will help your condition.
Positive politeness no. 1: Give reasons	Students redress patient face by including patient in practical reasoning, and leading patient to see soundness of treatment regimen.	11	All that I want to do is to help you. I'm not trying to run your life—I'm just trying to help you to understand that if you continue to eat as you have in the past, you are very likely to have a severe heart attack in the near future which could take your life.
Positive politeness no. 2: Assert reciprocity	Students satisfy patient wants, thereby redressing patient face and shaping a context for mutual cooperation.	3	All right, then, tell me those things that you want to eat. Let me at least help you to organize a diet that you want.
Empathic responding	Students identify content and surface feelings expressed by patient, thereby indicating that they have listened to and understood patient.	5	I understand it can be frustrating having so many people giving you advice, but that's the only way we know of to achieve the best care for you.
Bald, on record statement	Students make a nonredressed statement.	5	If you don't need someone to organize your life, then why are you here?

interview, however, patients are required to present a 'patient face', which may be quite different from their face of choice. In this therapeutic context, they are required to negotiate the authenticity of this abnormal state with their doctors. When doctors diagnose patients as being ill, they legitimize their claims to patienthood. However, when they recommend therapeutic lifestyle changes, doctors threaten patient face insofar as their prescriptions for change (1) may be interpreted as disapproval of patients' current behaviors and (2) set limits on their future lifestyle options. We assume that if patients become emotional and respond defensively to physicians' recommendations, as happened in our hypothetical vignette, issues of face preservation are likely to be involved. In situations like these, doctors need ways of assessing, acknowledging, and redressing any damage to patient face that might be attributable to their remarks [11]. Research has shown that patients typically assume that their physicians are technically competent, but they also want to see signs of warmth and interest. If physicians can respond to patients with face preserving linguistic gestures (closely associated with our lay notions of respect) then they will be better able to convey to patients their interest in them as individuals [17]. The development of communicative competence is also therapeutically necessary because the quality of doctor-patient interactions has been found to predict patient compliance with medical advice [15].

By issuing the angry challenge, "You can talk to me all you want, but I will *not* follow that diet. I have

had it with all of you telling me how to organize my life," our hypothetical patient put any further interaction in jeopardy. Politeness theory provides physicians with a way of interpreting the incident and restoring communication. An appropriate physician response to this distressed patient ideally would be both polite by redressing patient face in culturally acceptable fashion, and therapeutic to the extent that it could facilitate mutual understanding and ultimately, compliance. The politeness strategy that we favor, *asserting reciprocity*, fulfills both requirements. It is both face saving and therapeutic because it draws patients into the process of treatment design and satisfies their desires not to be imposed upon. The sample response, "All right, then, tell me those things that you want to eat. Let me at least help you to organize a diet that you want," is representative of this preferred response type. Unlike more traditional strategies that place patients in passive compliant roles, a strategy that asks patients to be decision makers empowers them [18]. It is consistent with a patient-centered approach to health care [19] and conforms to a model of mutual participation in doctor-patient relationships [20]. When physicians verbally transform treatment regimens from prescribed tasks to mutual endeavors, they also create a favorable context for mutual cooperation. Mutual agreement between doctors and patients over the definition of problems, priorities, means of evaluation, and therapeutic decisions and expectations is an essential component of the doctor-patient relationship. Without any introduction to theories that

would enable them to interpret their verbal behaviors, however, only 3% of students used a variant of this preferred strategy.

Eleven percent of students tried explaining to the patient why his/her diet had to change. For example, "All that I want to do is to help you. I'm not trying to run your life—I'm just trying to help you to understand that if you continue to eat as you have in the past, you are very likely to have a severe heart attack in the near future which could take your life." By *giving reasons*, students draw patients into their practical reasoning processes and consequently redress face. Nevertheless, while the strategy of explaining the rationale for an imposition is culturally acceptable, it may also be less effective than one that transforms an imposition into a mutual endeavor. When patients perceive that they lack control over their own treatment, noncompliance is the likely outcome [21]. Even after physicians *give reasons*, their treatment regimens remain prescriptions for change, often in conflict with patient desires not to be imposed upon.

Of all of the politeness strategies, *apologizing* or *admitting the impingement* was the most widely employed. Over 35% of the students responded to the patient's emotional reaction by apologizing for prescribing the treatment regimen. For example, "I'm not going to pretend that following this diet is going to be easy for you—it's going to be a real pain. Really, I'm not telling you how to run your life. I'm only suggesting a way to make your health better because I'm concerned about you as my patient." This strategy loses some of its therapeutic value because it highlights the distasteful aspects of the recommended treatment plan. It also implies that patients need to adhere to prescribed, rather than negotiated, regimens and that the physician-patient relationship is more hierarchical than egalitarian.

Another group of students (14%) shifted responsibility for their face threatening behavior from themselves to some other, unnamed medical authority. The example, "My suggestions are simply derived from my medical training and practical experience. Both have shown me that the diet will help your condition," illustrates this strategy. To the extent that students defined themselves as mouthpieces for an anonymous medical authority, they transformed what was meant to be an interaction between individuals into an encounter between facades or roles. In this kind of encounter, interpersonal understanding, which relies on processes of mutual accommodation between *individuals*, is impossible [12]. Therapeutic patient compliance is also unlikely following this kind of interaction because the physician has taken no personal responsibility for his/her recommendations.

The negative politeness strategy of answering the patient with a question or a hedge may be appropriate in the context of an egalitarian relationship because it conveys an unwillingness on the part of the physician to coerce or impose. However, the strategy delays conflict resolution, and may not necessarily facilitate conversational repair. By answering the angry patient with a question, "Do you understand why we prescribed that diet for you?", students (26.5%) may have conveyed their unwillingness to coerce. But if the patient were to respond negatively,

this strategy could increase tension and precipitate further conversational breakdown.

Empathic responding can be an effective strategy for reopening communication once it has shut down. The student who says, "You sound frustrated and angry that your condition is causing so many changes in your life" redresses patient face by acknowledging the imposition associated with prescribing dietary changes. This technique also gives the patient time to rethink his/her challenge and creates a new conversational opening. However, as a new and unfamiliar form of response (only 5% of the students responded in this fashion) it is less likely than the others discussed to become part of the physician's repertoire without repeated practice. Furthermore, it needs to be introduced within a theoretical framework that clarifies its rationale and potential for effectiveness. Politeness theory can be used to provide this framework.

In contrast with polite forms, no attempt is made in *bald on record statements* to redress face [11]. They are concise, direct and frequently combative as the following example illustrates: "If you don't need someone to organize your life, then why are you here?" A paraphrase of this physician statement as "my job is to tell you what to do", reveals its inappropriateness for use within the kind of egalitarian physician-patient relationship that we advocate. Only a small number of students replied to the hypothetical patient with bald on record statements (5%), indicating that prior to training, most have reservations about using such confrontational tactics. It is not clear, however, that students appreciate why they need to avoid such linguistic behavior in other situations with other patients.

CONCLUSION

The therapeutic success of physician-patient interactions depends in large part on how physicians interpret and respond to patient's implicit and explicit messages. Our hypothetical vignette depicted a patient's emotionally charged rejection of treatment recommendations advocated by his/her physician. The theories of politeness and strategic interaction provide a framework for understanding what might have triggered the patient's emotional behavior and how the incident might be resolved so that both doctor and patient can accomplish their therapeutic goals.

The data indicate that, prior to classroom training, first-year medical students who responded to our patient vignette produced appropriately face preserving, or polite, responses in a situation that called for face redress and conversational repair. But, not all culturally appropriate responses are necessarily therapeutic. We evaluated all of the students' responses on the basis of how well they (1) redressed patient face, (2) repaired conversation, and, (3) *created a therapeutically beneficial context for mutual participation and understanding between doctor and patient*. We proposed that of all the strategies, *asserting reciprocity* was most preferable because it was both culturally appropriate and therapeutically effective. As our data indicated, very few untrained students responded in this fashion. Once students' awareness

is raised through an understanding of this framework it is likely they can learn to convey effectively the respect they have for their patients and establish grounds for cooperative, patient-centered communication. Brody [18] has theorized that patients who participate in clinical decision-making should have greater confidence in and commitment to mutual decisions. We also want to argue that patients are more likely to comply with therapeutic regimens negotiated in a context where physician and patient goals are perceived as reciprocal.

A major problem for any discipline, such as anthropology or counseling psychology, that seeks to expand its service to medicine is that it must establish its credibility and usefulness in a new arena [22]. Counseling psychology has had a positive impact on medical education to the extent that empathic interviewing techniques are currently being taught in the classroom. But in order to make future doctors even more responsive to patient needs and desires, we need to give them frameworks for understanding and evaluating their communicative behavior long after they have left the classroom. The disciplines of anthropology and linguistics may provide an untapped source for many of these frameworks.

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