University of Nottingham
UK | CHINA | MALAYSIA

INNERVATE
Leading undergraduate work in English studies

Volume 16: 2023-24 ISSN: 2041-6776

Examining the Influence of Politeness in Power Through Medical Relationship Videos

Yingya Li

Introduction

Active communication between people is the bridge to building good relationships. In healthcare, polite communication is vital to shaping positive relationships among patients, medical teams, and between doctors and patients. There are different forms of communication, such as written communication, telephone communication, and face-to-face communication. Vermeir et al. (2015) argue that face-to-face communication is more efficient than written communication because it allows for the interpretation of body language and facial expressions, which enhance understanding and reduce miscommunication. Stewart (1995) finds a correlation between effective doctor-patient communication and improved patient health outcomes, with high-quality communication benefiting patients' health in ways such as soothing mood and relieving symptoms. In that case, polite and effective communication between doctors and patients can clarify the patient's needs, alleviate the patient's negative emotions, and facilitate the patient's recovery. Communication is a two-way activity. However, if communication is insufficient (such as lacking clarity, timeliness or completeness), it can adversely affect the medical process by leading to misdiagnoses, treatment delays and

reduced patient safety. According to Ratna (2019), a lack of communication can reduce healthcare quality, increase ineffective costs, and cause negative emotions in patients. Vermeir et al. (2015) have the same view: inefficient communication can lead to negative consequences such as wasting time and resources, compromising patient safety, and interrupting care. In that case, effective communication can reduce wasted time and money. Superb medical skills and polite communication are essential elements that reflect a doctor's professionalism. Therefore, effective and polite communication is essential in the healthcare field.

In effective communication, politeness is a necessary communication attitude and principle. Research by Ng et al. (2016) argues that politeness strategy in communication can help patients and doctors establish better self-awareness and self-observation, leading to more effective communication between doctors and patients in the medical environment. It is because politeness strategy can reduce face-threatening behaviors, enable doctors to pay more attention to patients' feelings in communication and adjust their expressions to enhance patients' trust. At the same time, patients need to listen and express themselves more carefully when using politeness strategies, allowing them to better understand their condition and the doctor's advice. This paper will explore the role and significance of politeness in healthcare settings, particularly how it influences power dynamics between doctors and patients. The interest in power arises from the hierarchical nature of medical interactions, where doctors traditionally hold institutional authority, and politeness strategies can either reinforce or mitigate this imbalance by shaping communication and patient participation. This essay explores the role of politeness in adjusting the balance of power in the doctor-patient

relationship through a detailed analysis of a video conversation between a doctor and a patient. The paper will be structured as follows: First, a literature review introduces vital theories and sets the stage for the analysis, such as Brown and Levinson's politeness theory, Alternative Model of (Im)politeness and Elite Theories of Power Dynamics. Second, the methodology section outlines the methods and criteria for video analysis. Third, an in-depth analysis of the selected data is performed. This detailed analysis of videos of doctor-patient relationship interactions can provide practical insights. The discussion section then critically evaluates the use of the politeness strategy and its impact on power relations. Finally, the conclusion summarizes the main findings and provides practical recommendations for healthcare professionals while suggesting future research in healthcare.

Literature Review

O'Shea, Boaz and Chambers (2019) emphasize the role of power in shaping healthcare relationships, emphasizing its impact on doctor-patient interactions and team dynamics. Dahl (1957) further elaborates on this idea by defining power as the ability to influence others, which is critical in healthcare. These power dynamics create hierarchies and inequalities, emphasizing the necessity of managing interpersonal dynamics effectively (O'Shea, Boaz, and Chambers, 2019). The interaction of power in these relationships paves the way for exploring how politeness can act as a balancing mechanism. On the other hand, Archer, Grainger and Jagodziński (2020) emphasize the importance of politeness in healthcare. They thought politeness is more than avoiding negative social consequences; it is essential for actively managing and building social relationships in stratified environment. Dimitrova-

Galaczi (2002) points out the complexity of politeness and the need for culturally sensitive understanding, particularly in power imbalances. It connects the relationship between power hierarchies, social interactions and politeness, and introduces different definitions of politeness.

The center of Brown and Levinson's Politeness Theory is the concept of 'face,' which is integral to understanding social interaction (Brown and Levinson, 1999). Drawing on Goffman's face theory (Goffman, 1972), Brown and Levinson (1999) found that 'face' relates to an individual's self-image or social value and affects their communication and behavior in the social environment. Brown and Levinson (1999) explore 'face' through positive face, which seeks appreciation, and negative face, which seeks autonomy and personal freedom. These concepts guide politeness strategy, including Face Threatening Acts (FTAs), which are behaviors that endanger another person's self-image (Brown and Levinson, 1999). Therefore, the politeness strategy is a tool for mitigating Face Threatening Acts, maintaining effective communication, and balancing authority and empathy, especially in healthcare.

In contrast, Locher and Watts (2005) propose an Alternative Model of (Im)politeness that regards politeness as needing to be context-dependent, consistent with the dynamic nature of healthcare interactions. Their Relational Work Theory emphasizes how the work language environments, social practices and power relations subjectively shape politeness and impoliteness. For example, in a hospital setting, hierarchical structures can influence communication, junior doctors may use deferential language when addressing senior doctors, while senior doctors might adopt a more direct tone when giving instructions. Social practices

such as shared decision-making in healthcare settings influence politeness by encouraging doctors to engage patients in discussions rather than using directive communication. Based on the Alternative Model of (Im)politeness, Spencer-Oatey (2000, 2008) introduced the Rapport Management Theory, expanding on the concepts of 'face' and politeness. This theory covers managing self-esteem, social rights and obligations, communication strategies, and cultural contextual factors. Rapport Management Theory emphasizes managing cultural and contextual factors in interpersonal dynamics, integrating concepts from Goffman, Brown and Levinson (1999). It provides special insights into the ways politeness is expressed within healthcare interactions, particularly by addressing cultural and contextual factors that influence relationship-building and maintenance. Different from Brown and Levinson (1999), it expands the focus from face-saving strategies to include broader aspects of social rights and interaction management.

Locher and Watts's (2005) Alternative Model can understand that interpersonal dynamics, whether politeness or power, can significantly impact social interactions. This connection becomes particularly evident in healthcare, where power dynamics play a crucial role, as highlighted by Mills (2018) and Cohen Konrad et al. (2019). Mills (2018) suggests that power is concentrated in the hands of a small number of economic elites, affecting political development and the healthcare system related to social structures. Cohen Konrad et al. (2019) further illustrate how these power structures manifest in healthcare settings, explicitly affecting the decision-making and leadership roles of medical staff. Their research demonstrated that power identities (often held by those in dominant positions) can significantly influence interactions and decision-making processes in healthcare. This observation

connects to Relational Work Theory, as doctor-patient collaboration guided by Politeness Theory and Rapport Management Theory may challenge and redefine these entrenched power dynamics, providing new insights into more egalitarian approaches in healthcare.

Research from Howick et al. (2018) showed that positive communication and empathy can help patients relieve pain and promote recovery. In their study, which analyzed twenty-eight experiments, doctors who communicated more compassionately and delivered positive messages were found to reduce patients' pain and anxiety effectively in most cases. Nearly half of the studies show that doctors communicating with patients more positively benefits patients' physical health. These findings highlight the transformative role of polite communication in health care and suggest a shift toward a more patient-centered approach. Repositioning not only impacts patient well-being but also involves redefining power dynamics in healthcare interactions, where politeness plays a crucial role in negotiating authority and control. By turning to a more patient-centered approach, healthcare professionals may use politeness strategies to balance institutional authority with patient autonomy. For example, instead of issuing direct commands, the doctor might phrase recommendations as collaborative suggestions like ‘Would you be open to trying this treatment?’, fostering a sense of shared decision-making while maintaining professional guidance.

Methodology

This study aimed to investigate politeness strategy and power structure in doctor-patient communication and explore their impact on the medical and healthcare. The source of the data is a simulated doctor-patient interaction in a YouTube video produced by Western

Michigan University Homer Stryker M.D. School of Medicine (WMed). This thirteen-minute video shows an informative dialogue between characters played by women, simulating the roles of patient and doctor. In order to conduct an in-depth examination, due to its rich discursive content and the diversity of the interactions presented, three different examples of the video were selected for this study. Three examples will be analyzed using Brown and Levinson's Politeness Theory, Alternative Model of politeness and Elite Theories of Power Dynamics. Selected dialogues with line numbers are included in the appendix for clarity.

This study used discourse analysis and politeness analysis as the main methods. Based on Brown and Levinson's Politeness Theory and further enriched by the Alternative Model of politeness and Elite Theories of Power Dynamics, this study provides a multifaceted perspective on the interaction between politeness strategy and power relations. As Benwell (2006) points out, discourse analysis helps to understand the distribution of power and ideology in dialogue and the role of language in shaping identity. This study uses discourse analysis to analyze the identity construction and power distribution between doctor and patient in the examples. In addition, politeness analysis can explain the role of politeness strategy in reducing conflict, fostering positive relationships, improving information efficiency, and examining expressions of politeness in communication as they relate to healthcare. Van der Bom and Mills (2015) suggest that politeness is a complex concept, if discourse analysis is used to analyze politeness, it is essential to focus not only on polite and impolite behaviors but also to consider the audience's perspective and discourse context.

In summary, this study will integrate these analytical methods to understand doctor-patient communication dynamics comprehensively. By analyzing conversations from the perspective of politeness and power, this study aims to gain insights into how politeness affects power structures and may lead to the development of more patient-centered approaches to healthcare.

Data Analysis

This study conducted a detailed discourse and politeness analysis of three selected conversations in the video using Brown and Levinson's Politeness Theory, Alternative Model of politeness and Elite Theories of Power Dynamics. These conversations were selected for their rich content and are included in the appendix with line numbers for reference.

A. Analysis of Example 1

In the initial part of the interaction, the title and open-ended questions used by the doctor were respectively consistent with the concepts of the negative and positive politeness strategies of Brown and Levinson. By addressing the patient as 'Miss Bellamy' and offering a choice of name preference like ‘Would you prefer Miss Bellamy or Pats’, the doctor demonstrates negative politeness by acknowledging the patient's social status and providing her with autonomy, to protect her ‘face’. The polite greeting ‘It’s nice to meet you’ and the open question ‘Can you tell me why you are here today’ reflect positive politeness strategies designed to build rapport and reduce pressure imposed by power.

From the perspective of the Alternative Model of politeness, the doctor's approach is patient-centred and indirect as in questions ‘Would you prefer Miss Bellamy or Pats’ and ‘Can

you tell me why you are here today', which are tailored to individual needs and represents a shift from the traditional authoritative and directive style of communication (Locher and Watts, 2005). This approach acknowledges the diversity of patient's personal experiences and the importance of cultural sensitivity in healthcare. Connected with Helen Spencer-Oatey's Rapport Management Theory (2000, 2008), these interactions can be viewed as efforts to balance social power and interaction goals in negotiation. By providing patient with options and engaging in polite greetings, the doctor can effectively manage rapport while focusing on the patient's needs of 'face' and the social harmony of the interaction.

Elite Theories of Power Dynamics also play a role, with traditional asymmetries in medical consultation. By soliciting patients' challenging title preferences like 'prefer Miss Bellamy or Pats', the doctor demonstrates a preparation to redistribute power, departing from the entrenched Elitist dynamics outlined by Mills (2018). This approach encourages a more equal dialogue and creates an environment conducive to patient autonomy.

However, the redistribution of power through polite discourse may appear more superficial than real. Despite ostensibly polite interactions, the inherent authority of medical professionals derived from expertise and institutional power persists. The doctor's choice of questions and direction of the conversation subtly guided the patient's response, reinforcing established power dynamics centered on the physician's knowledge and role. Spencer-Oatey's Rapport Management Theory (2000, 2008) enhances this analysis by acknowledging the interplay between face needs and social power in interactions. It demonstrates that while doctors' politeness strategy can mitigate apparent power imbalances, they cannot entirely

eliminate entrenched social hierarchies. Doctors' consideration of patient preferences and comfort may alleviate patients' feelings of subordination, but it does not fundamentally change the power structure in medical consultations. Therefore, the purpose of using politeness and considering patient preferences is to manage rapport instead of redistributing power. Medical environments inherently position doctors as decision-makers, and politeness strategy may serve more to maintain the appearance of a collaborative interaction than truly democratize the doctor-patient relationship.

B. Analysis of Example 2

In Example 2, the doctor demonstrated a combination of Brown and Levinson's positive and negative politeness strategies. Inquiries about other health concerns like ‘Is there anything else besides your headache that you want to address here today to the clinical problem’ are a sign of negative politeness that allows the patient to maintain autonomy and control over the disclosure of personal health information. It demonstrates strategic respect for the patient's private sphere, encouraging them to share at their comfort level. The sentence ‘I will have my office secretary look into it the insurance planning you have’ shows positive politeness, and the doctor focuses on patients' practical problems in addition to direct medical issues. This holistic approach to care involves not only managing clinical symptoms but also addressing underlying stressors that may hinder a patient's overall health.

Through the Alternative Model of politeness, the doctor’s concern for a patient's financial problems demonstrates sensitivity to the broader socioeconomic context of health, which is being patient-centered and responsive to individual circumstances: ‘I will have my

office secretary look into it the insurance planning you have'. It is consistent with the need for healthcare providers to recognize and accommodate diverse patient backgrounds and expectations, which is also consistent with the core tenets of Spencer-Oatey's Rapport Management Theory (2000, 2008). Rapport Management Theory posits that effective communication is achieved by managing social rights, such as equality and autonomy, and interaction goals, such as relationship building and information exchange.

Within the framework of Elite Theories of Power Dynamics, the doctor's sympathetic comment 'Looks really bad' and subsequent inquiry 'Is there anything else' serve a dual purpose. The doctor demonstrates professional authority by providing assessments of patients' conditions while inviting patients into conversations that undermine traditional power hierarchies. This approach reflects the application of Rapport Management Theory, whereby doctors use power to encourage more inclusive and participatory conversations, strengthening rapport and potentially improving health outcomes (Mills, 2018; Spencer-Oatey, 2000; Spencer-Oatey, 2008).

However, despite the redistribution of power that occurs through shared decision-making, the inherent authority of medical professionals remains. The doctor's guidance determines the patient's response and the overall trajectory of the consultation. Rapport Management Theory emphasizes that although accommodating face needs and social rights can help reduce the power gap between doctors and patients, it cannot completely eliminate it (Spencer-Oatey, 2008).

C. Analysis of Example 3

The positive and negative politeness strategies were analyzed first. For example, when the doctor wants to get more information as ‘would it be okay if I took some notes’, she uses wording that respects the patient's autonomy, reflecting negative politeness. At the same time, words such as ‘perfect’ and the frequent use of ‘okay’ reflect an active politeness strategy aimed at cultivating a supportive and collaborative doctor-patient relationship (Brown and Levinson, 1999). However, there is a more critical interpretation of these strategies. For example, while the doctor's language is inclusive and empathetic, it is essential to consider whether these strategies are truly empowering to the patient or simply to maintain the decorum expected in healthcare. Using questions like "tell me a little bit more" and ‘can you tell me anything’ can be interpreted as a soft directive, subtly guiding the conversation while ostensibly providing patient control right.

Combined with the Alternative Model of politeness, the analysis of this example approved the doctor's empathetic statements about environmental constraints, which reflects a patient-centered approach. However, it is critical to evaluate whether expressions of empathy truly enhance patient comfort or are merely an acknowledgment of inconvenience: ‘unfortunately I can't dim the lights in this room’. Additionally, a promise to ‘try to go quickly’ can be seen as an attempt to minimize patient discomfort and respond to the patient's preferences if possible, but this can also turn into a situation that rushes the visit, thereby affecting the quality of care (Locher and Watts, 2005; Spencer-Oatey, 2000; Spencer-Oatey, 2008).

Elite Theories of Power Dynamics are used to highlight the power imbalance inherent in doctor-patient interactions. The doctor's expertise naturally places her in a dominant position. However, her efforts to elicit detailed patient narratives demonstrate her attempt to democratize communication: ‘tell me a little bit more’ and ‘try to go quickly’. However, it must be critically evaluated whether these efforts are sufficient to counteract the entrenched power dynamics in healthcare. For example, a patient's consent to a doctor's recommendations may be interpreted as compliance rather than actual participation (Mills, 2018).

While physicians' actions aim to balance authority and care, they also raise questions about the performative aspects of politeness in medical interactions. Whether the display of politeness masks underlying power structures or whether it becomes a real tool to empower patients, the tension between superficial politeness and deeper power controls deserves further exploration.

Discussion

Using Brown and Levinson's Politeness Theory, Alternative Model of politeness and Elite Theories of Power Dynamics as frameworks, this paper delves into the subtle interaction between politeness and power by exploring healthcare communication. First, the application of both positive and negative politeness strategies can help develop a constructive doctor-patient relationship. Positive politeness is characterized by comforting and affirmative communication and promotes trust, whereas negative politeness recognizes patient autonomy and enhances patient involvement (Brown and Levinson, 1999). Second, considering the patient's demands and striving to increase comfort is consistent with the Alternative Model of

politeness. Actions such as resolving insurance issues demonstrate a combination of professionalism and humane care that prioritizes patient-centeredness (Locher and Watts, 2005). However, it is crucial to assess the extent to which such practices truly empower patients or simply follow expected behavior. Third, although doctors inherently possess authority because of their expertise, there are conscious efforts to moderate this dynamic. By soliciting patient input and participating in shared decision-making, physicians can distribute power more equitably and create an interactive and collaborative treatment environment (Mills, 2018).

However, the power dynamic between doctors and patients is inherently unbalanced, and the doctor's authority often overshadows the patient's voice. To alleviate this situation, a balanced approach that intersects authority with compassion is necessary. While politeness strategy is helpful in building rapport, it cannot overshadow patient needs and autonomy. Encouraging patients to express their concerns openly is one step in empowering them during the consultation process. In addition, the use of politeness must be sensitive to different cultural backgrounds and personal experiences, ensuring that the medical environment respects and adapts to the individual patient's narrative (Spencer-Oatey, 2000; 2008).

In summary, while politeness strategy is critical in healthcare communication, it must be critically evaluated and applied in a manner that respects patient autonomy and cultural diversity, which help distribute power more equitably and enhance overall patient care. Further research may explore how these strategies work in different cultural contexts and the impact of patient involvement on treatment outcomes.

Conclusion

In conclusion, this paper critically explores the interaction of politeness and power in healthcare communication, employing frameworks like Brown and Levinson's Politeness Theory, Alternative Model of politeness and Elite Theories of Power Dynamics to reveal the complexity of doctor-patient interactions. The findings highlight the importance of using politeness as a communication tool in healthcare to promote rapport, trust, and patient engagement while also acknowledging the ongoing power imbalance inherent in the doctor-patient relationship. The analysis shows that positive and negative politeness strategies can help bridge the gaps and imbalances created by inherent authority in health care. Through affirmative and supportive language, positive politeness creates a comfortable atmosphere that can reduce patient anxiety and contribute to a more trustworthy medical experience. Negative politeness emphasizes respecting patient autonomy and providing choices, recognizing patients' right to self-determination and enhancing their participation in medical conversations (Brown and Levinson, 1999).

However, while the politeness strategy ostensibly redistributes power, it actually preserves part of the hierarchy in healthcare. The physician's role as primary knowledge holder and decision-maker is not compromised, and polite discourses help guide rather than negate this dynamic. Rapport Management Theory acknowledges the effort to balance relationship demands with task goals while also maintaining counseling balance. Politeness strategy in communication is good for building relationships, and patients' needs and autonomy should be respected and encouraged to express their health problems freely.

Additionally, sensitivity to cultural diversity and personal experiences is critical because these factors can profoundly impact patient comfort and communication in healthcare.

Therefore, this paper found that politeness and power interact in healthcare communication. Enhanced patient care through strategic management is effective. Balancing authority with humanity and combining a patient-centered approach with expertise is a subtle but essential practice. It requires critical evaluation to understand the patient's individual needs and background (Locher and Watts, 2005). Further research investigating politeness and power dynamics in different cultural contexts and their impact on treatment effectiveness could be considered. Research could provide a deeper understanding of how communication strategies can be tailored to support patient empowerment and improve health outcomes. As healthcare continues to evolve, doctors are advised to be more respectful and compassionate to their patients.

References

Archer, D., Grainger, K., & Jagodziński, P. (2020). *Politeness in Professional Contexts.* (1st ed., Pragmatics and Beyond New Ser). John Benjamins Publishing Company.

Benwell, B. (2006). *Discourse and identity*. Edinburgh University Press.

Brown, P., & Levinson, S. C. (1999). *Politeness: some universals in language usage. I: The discourse reader.* A. Jaworski and N. Coupland (eds.). London–New York. S, 321-335.

Cohen Konrad, S., Fletcher, S., Hood, R., & Patel, K. (2019). Theories of power in interprofessional research–developing the field. *Journal of interprofessional care*, *33*(5), 401-405.

Dahl, R. A. (1957). The concept of power. *Behavioral science*, *2*(3), 201-215.

Dimitrova-Galaczi, E. (2002). Issues in the Definition and Conceptualization of Politeness. *Studies in Applied Linguistics and TESOL*, *2*(1), 1-20.

Goffman, E. (1972). *Interaction ritual: essays on face-to-face behaviour*. Penguin.

Howick, J., Moscrop, A., Mebius, A., Fanshawe, T. R., Lewith, G., Bishop, F. L., ... & Onakpoya, I. J. (2018). Effects of empathic and positive communication in healthcare consultations: a systematic review and meta-analysis. *Journal of the Royal Society of Medicine*, *111*(7), 240-252.

Locher, M. A., & Watts, R. J. (2005). Politeness theory and relational work. *Journal of Politeness Research*, *1*(1), 9-33.

Mills, C. W. (2018). The power elite. In *Inequality in the 21st Century* (pp. 80-88). Routledge.

Ng, C. F., Ng, P. K., & Ng, C. Y. (2016). Politeness in doctor-patient communications: A pilot study. *Middle East Journal Of Scientific Research*.

O'Shea, A., Boaz, A. L., & Chambers, M. (2019). A hierarchy of power: the place of patient and public involvement in healthcare service development. *Frontiers in sociology*, *4*, 38.

Ratna, H. (2019). The Importance of Effective Communication in Healthcare Practice. *Harvard Public Health Review*, *23*, 1–6. https://www.jstor.org/stable/48546767.

Spencer-Oatey, H. (2000). Rapport management: A framework for analysis. *Culturally speaking: Managing rapport through talk across cultures*, *1146*.

Spencer-Oatey, H. (2008). Face, (im)politeness and rapport. In 1952 Spencer-Oatey Helen (Ed.), *Spencer-Oatey, Helen, 1952* (pp. 11–47). Continuum International Publishing Group.

Stewart, M. A. (1995). Effective physician-patient communication and health outcomes: a review. *CMAJ: Canadian medical association journal*, *152*(9), 1423.

Van der Bom, I., & Mills, S. (2015). A discursive approach to the analysis of politeness data. *Journal of Politeness Research*, *11*(2), 179-206.

Vermeir, P., Vandijck, D., Degroote, S., Peleman, R., Verhaeghe, R., Mortier, E., ... & Vogelaers, D. (2015). Communication in healthcare: a narrative review of the literature and practical recommendations. *International journal of clinical practice*, *69*(11), 1257-1267.

Western Michigan University Homer Stryker M.D. School of Medicine. (2015, July 9). *Communication skills: A patient-centered approach*. YouTube. https://www.youtube.com/