This article has been published in:

The Palgrave Handbook of Linguistic (Im)politeness. Jonathan Culpeper, Michael Haugh and Dániel Z. Kádár (eds.). London: Palgrave Macmillan, 2017, 689–711.

(Im)politeness in health settings

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1. Introduction

As Mullany (2009) points out in her introduction to the special issue on health and (im)politeness in the *Journal of Politeness Research,* 'applying politeness research to health care communication' is a fairly recent but rewarding area of research within applied linguistics. Even when we include the studies she points to (Robins and Wolf 1988; Lambert 1995, 1996; Speirs 1998; Grainger 2002, 2004; Jameson 2003; Norris and Rowsell 2003; Delbene 2004; Woolhead et al. 2006), add the six contributions in her 2009 special issue (Backhaus; Brown and Crawford; Graham; Harrison and Barlow; Mullany; Zayts and Kang), and take further sources into account, we can still concur with Mullany that 'overall there is a real necessity for empirical investigations to be produced in a wide variety of health care contexts' (p. 1). In this chapter, we review some of the issues that transpire in the current research field and add observations of our own.

Before going into a literature review on the intersection of the study of (im)politeness and health communication which entails an introduction to

key concepts and theories (Sect. 2), some comments on the scope of the terms are in order. In a narrow sense, '(im)politeness' in its emic understanding refers to what people in a particular social practice understand by the terms 'politeness', 'impoliteness', 'rudeness', etc. While there are larger societal norms that display ideologies about social behaviour, there can also be considerable local differences in the practices of individual groups (see Leech 2014; Locher and Watts 2005). However, the term (im)politeness can also be used as a shorthand for referring to facework/relational work/rapport management in general. With this larger lens in mind, scholars are interested in situated pragmatic rules that show how social interactants negotiate relationships and get 'things

Published in: doi.org/10.1057/978-1-137-37508-7_26

done' by means of language without jeopardising the social balance or how people exploit linguistic means in more conflictual situations to get their points of view across and to save, maintain or challenge each other's face (for a thorough introduction to the notion of face, see O'Driscoll (Chap. 5), in this volume). Studies with such a larger (im)politeness lens often look at particular interpersonal strategies, such as the use of humour, mitigation strategies and address terms, in order to report on patters in relational work (see Locher and Graham 2010, on the scope of interpersonal pragmatics).

Linking these observations to our health context, it is important to first point out that the combination of health and communication is a vibrant research field with a long tradition (for overviews, see, e.g., Hamilton and Chou 2014; Harvey and Koteyko 2013; Collins et al. 2011; journals such as *Communication and Medicine).* Many different research disciplines contribute to this field from social psychology, communication studies, health literacy, medical sociology, medical anthropology, education, pragmatics and applied linguistics. The object of study is equally diverse including different interactions between different combinations of interactants (healthcare provider-healthcare provider, healthcare provider-patient, patient-patient, carers-patients, etc.), ideologies and discourses around health and different modes and interaction and their combinations (face-to-face, telephone, leaflets, case reports, e-health contexts, etc.). Hamilton and Chou (2014, p. 1) report on dusters of research on 'patient-provider communication,' 'mental health and counseling,' 'narrative as related to cognition and illness experience,' and the 'discourse of public health.' They go on to organise the 40 chapters in their handbook (which is compiled with applied linguists in mind) around the themes 'individuals' everyday health communication,' 'health professionals' communicative practices,' and 'patient-provider communication in interaction.' Davis (2010, p. 382) argues that there are four distinct groups of researchers with different training who study language use in particular in medical contexts: linguists who study health discourse; clinical linguists who work on language

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disorders; health communications studies specialists; and clinicians who are persons trained in clinical practice and who aim at improving communication. They all have in common that they look at language, observe linguistic patterns and offer interpretations from their different points of view. Health practitioners have long been interested in studying their communication and in discovering best practices and problems in an attempt to improve healthcare services and 'to enact more effective care and achieve more favourable patient outcomes as a result of better communication' (Davis 2010, p. 382).

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As a result, the following selection of health buzz issues touches on concerns central to both health communication and interpersonal pragmatics (as defined by Locher and Graham 2010): patient empowerment, the creation of rapport between doctor and patient, the use of persuasive strategies to encourage patients to adhere to treatment (e.g. by means of humour, mitigation, the use of lay vocabulary and the avoidance of jargon, etc.), the creation of trust and expertise or how to deal with face-threatening situations of having to break bad news or imparting information without giving advice.

Published in: doi.org/10.1057/978-1-137-37508-7_26

This is because the situated practices that evoke expectations about actions and roles, the dynamic negotiation of face and norms, and the resulting identity construction and relationship negotiation are often at the heart of these studies. In many cases, however, the literature on health and communication does not use theories of (im)politeness as a starting point for their analyses despite studying the same or similar surface phenomena. As a consequence, scholars interested in relational work and (im)politeness in health communication may find many more studies relevant for them when expanding their searches beyond the keywords (im)politeness. Having said this, it is beyond the scope of this chapter to give an overview on language and health communication in general. In what follows, we will thus first elaborate on a number of key studies that combine an interest in interpersonal language use and (im)politeness studies in health contexts (Sect. 2), before elaborating on a set of interlinked key themes that we will illustrate with data (Sect. 3). We will conclude the chapter by offering an outlook to further research (Sect. 4).

2. Key concepts and theories: (Im)politeness in healthcare contexts

Research on (im)politeness in healthcare is as diverse and varied as the general scope of language and health communication briefly described above. This diversity is reflected in the different healthcare contexts that studies have looked at, the different types and forms of communication and participants
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involved in the interactions that characterise these contexts, as well as the different 692 ↓
theoretical frameworks on which this research draws. While it would go beyond the scope of this chapter to provide a comprehensive review of all these different aspects, we aim to provide only a brief summary here and illustrate some of the overall trends and tendencies that characterise recent research on (im)politeness in healthcare settings. We will concentrate first on the scope of research and will then zoom into the emerging topics of e-health, culture, and theory and method in order to illustrate key issues and theories.

2.1 Scope of research

In addition to focusing on relatively traditional institutionalised contexts (such as hospitals or general practices) where many studies are located (e.g. Agledahl et al. 2011; Ojwang et al. 2010; Zayts and Schnurr 2013), (im)politeness research is increasingly conducted in other, perhaps slightly less mainstream, medical environments. For example, Woolhead et al. (2006) and Backhaus (2009) analyse the use of (im)politeness in social care settings, Davis and Kelly (2012) focus on counselling services, and Bromme et al. (2012), Graham (2009) and Locher (2017) look at different educational environments. In addition, research on internet-related healthcare environments is on the rise (e.g. Gallardo and Ferrari 2010; Harrison and Barlow 2009; Harvey and Koteyko 2013; Locher 2006, 2010). Researchers have also started to expand on the literature on professional-lay interactions, such as those between nurses and patients (Zayts and Schnurr 2013; Ojwang et al. 2010), care home staff and clients (e.g. Woolhead et al. 2006; Temple et al. 1999),

Published in: doi.org/10.1057/978-1-137-37508-7_26

stroke patients and health professionals (Grainger et al. 2005), and between tutors and medical students (Bromme et al. 2012) – just to name a few. Moreover, intra-professional encounters, for example among doctors (Gallardo and Ferrari 2010) and among healthcare professionals with different specialisations, such as pharmacists, physicians, and nurses (Lambert 1995; Graham 2009) receive more and more attention. A relatively underresearched area seems to be that of (im)politeness in interactions among patients, which only a handful of studies have investigated to date. One of these studies is Harrison and Barlow (2009) who analyse the occurrence of specific politeness strategies in relation to advice giving in the online feedback that patients with arthritis give each other as part of an online self-management programme. They observed that in performing the potentially face-threatening acts of giving advice and criticising each others' weekly action plans via emails and postings on an online discussion board, the patients frequently used ↑
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short personal narratives to express empathy while giving advice relatively indirectly. This 693
technique is particularly effective in this specific healthcare context as it enables 'advice ↓
givers to avoid being prescriptive while at the same time demonstrating empathy and shared concerns with the recipient' (Harrison and Barlow 2009, p. 108; Thurnherr et al. 2016).

2.2 e-health

Harrison and Barlow's (2009) study also shows that there is a growing interest among researchers on (im)politeness to analyse other forms of communication rather than the traditional face-to-face interactions. In addition to the emails and postings on online discussion boards that they looked at, other studies have conducted research on telephone interactions (e.g. Brown and Crawford 2009), and a range of other computer mediated forms of communication, such as an online discussion forum for doctors (Gallardo and Ferrari 2010), and a range of different healthcare-related websites (e.g. Locher 2006 2010; Oh et al. 2012). For example, in a study on websites that promote safe-sex behaviours Steehouder (2005) investigates the use of facework to effectively communicate potentially face-threatening information on this taboo topic. He shows that by creating specific sets of roles for authors and readers, these websites skilfully manage to do the FTAs of criticising current opinions and behaviours of the readers as well as imposing specific behaviours on them. Constructing and strategically drawing on specific sets of roles (expert-unknowing; consultant-advice seeker; instructor-follower; and peer-to-peer) enables the website users to communicate the various FTAs in relatively direct, on-record and yet non-face-threatening ways. For example, by taking on the role of expert it becomes acceptable for an author to answer questions (e.g. posted by other users in the Frequently Asked Questions Section) and to deliver information often in a rather schoolbook like fashion. Similarly, taking on the roles of peers may facilitate talking about topics that might be considered taboo for an interaction among strangers (e.g. sex).

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The notion of role has received some attention in the literature on medical communication (e.g. Sarangi 2000, 2010; Zayts and Schnurr 2014) and is as important for e-health practices as it is for face-to-face interaction. It is generally understood as a discursive accomplishment which is always to some extent co-constructed, subject to change, and dependent on the context (e.g. Roberts and Sarangi 1999). In the medical context, interlocutors (often strategically) draw on different roles which are to some extent co-constructed between those participating in the interaction taking into ↑ consideration 693
the institutional context in which the interaction takes place. Interlocutors thereby skilfully 694 negotiate the various (and sometimes opposing) demands of the medical context and ↓ profession, on the one hand, and the clients' expectations, on the other (Zayts and Schnurr 2014). They thus engage in intricate emergent negotiations of identity construction and relationships. Locher and Hoffman's (2006) work on the fictional agony aunt Lucy in an online advice column demonstrates how carefully the health team responsible for the column uses language to create an approachable yet informed persona through entirely linguistic means, who is appealing to the target audience of college students. For an in-depth discussion of the interface of (im)politeness and identity construction, see Garcés-Conejos Blitvich and Sifianou (Chap. 10), in this volume.

2.3 Culture

Another topical strand that runs through the research on (im)politeness in healthcare settings is that of culture. Since the relationship between (im)politeness and culture has long captured the interest of researchers, it is perhaps not surprising that this is also the topic of several research studies in the healthcare context. More specifically, (im)politeness phenomena have been researched in a wide range of different sociocultural contexts, as, for example Australia (e.g. Davis and Kelly 2012; Iedema 2005), Hong Kong (e.g. Zayts and Kang 2009; Zayts and Schnurr 2013), Kenya (Ojwang et al. 2010), Latin America (e.g. Gallardo and Ferrari 2010), Norway (e.g. Agledahl et al. 2011), the United Kingdom (e.g. Harrison and Barlow 2009), and the United States (e.g. Graham 2009; Locher 2006). These studies have identified and described some of the discursive strategies and pragmatic processes through which participants in these sociocultural contexts do (im)politeness in a wide range of healthcare settings. One of the few studies which specifically focuses on the phenomenon of impoliteness is Ojwang et al. (2010). Their study of nurses in a Kenyan hospital discusses the frequent use of impoliteness and abuse uttered by the nurses towards their patients. They show some of the strategies through which the nurses regularly attack the patients' face and the responses this generates. Although in most cases the nurses did not employ any mitigating strategies when issuing their impolite comments, such as criticisms, blame, sarcastic remarks, and reprimands, which often violated the patients' dignity, the patients were generally more concerned with preserving both their own and the nurses' face. In order to reclaim their dignity they ↑ typically responded with either silence, retaliatory face damage or face repair. 694

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The remarkably high frequency of impolite behaviour by the nurses which was observed in this particular hospital is explained with reference to the social power differential that exists between the nurses and their patients, and the perceived vulnerability and powerlessness of the latter in this context. What is particularly interesting about this study is the authors' comment at the end that this situation 'is not in accord with what is considered Western best practice in hospital settings' (Ojwang et al. 2010, p. 521). 695 ↓

However, in spite of this interest in (im)politeness in healthcare in a range of different sociocultural contexts, there is only a relatively small number of studies which focus on (im)politeness in intracultural and intercultural encounters (e.g. Graham 2009; Mason 2004; Zayts and Kang 2009). But several comparative studies exist which explore the use of (im)politeness in medical settings in different sociocultural contexts, such as Backhaus' (2009) analysis of politeness in elderly care facilities in Japan, in which he compares his observations with the findings of previous studies in a similar context in countries as diverse as South Africa, Germany and the United Kingdom. He observed remarkable similarities regarding the use of positive politeness strategies in instances of praise, and inclusive as well as exclusive joking displayed by interlocutors in care homes across these countries. These similarities are interpreted as pointing to 'some universal communicative properties in this special type of health care setting' (Backhaus 2009, p. 67). Due to the relatively similar institutional characteristics and practices of these settings, e.g. in terms of power difference and social distance between interactants, as well as the seriousness of the FTAs involved, it is perhaps not surprising to find a high degree of similarity in the use of verbal strategies to do politeness (but see Ojwang et al. 2010, above). Thus, rather than referring to potential cultural differences, this study shows that the everyday practices that characterise the care home context may be more relevant in accounting for the use of (im)politeness.

This critical stance towards using culture as an explanation for observed differences in (im)politeness is also reflected in other studies in the healthcare context. In line with recent developments in research on intercultural communication, there is an increasing acknowledgement among politeness researchers that treating culture as an a priori explanatory variable to account for observed differences in (im)polite behaviour is not a very fruitful exercise as it dramatically oversimplifies a rather complex situation and runs the danger of reinforcing stereotypes (e.g. Eelen 2001; Mills 2003, 2004; Watts 2003). For example, in a study on prenatal screening in Hong Kong, Zayts and Schnurr (2013, p. 188) argue that researchers should 'focus on how meaning is created and negotiated at the micro-level of an interaction, and to move away from 'grand generalisations' about the impact of culture specific ↑ 695
behaviours and expectations' on the way in which people use (im)politeness. They propose 696 ↓
that using the framework of relational work (Watts 2003; Locher and Watts 2005) is one way forward as it 'encourages analyses that view both politeness and culture as discursive constructs' (Zayts and Schnurr 2013, p. 190). According to this theoretical framework, notions of what is considered to be polite, impolite, or politic behaviour are dynamically negotiated among participants in a specific encounter. Thus, rather than assuming that

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culture per se influences participants' behaviour in terms of (im)politeness, employing the framework of relational work shifts the focus onto analyzing how specific cultural aspects (such as sociocultural norms) are actually oriented to and negotiated as an interaction unfolds.

2.4 Theory and method

The immense diversity of research on (im)politeness in healthcare contexts in terms of interactional setting, participants, and form of communication is further reflected in the different methodological and theoretical approaches that researchers have taken when exploring issues of (im)politeness in healthcare contexts. Zayts and Schnurr's (2013) study is also a good illustration of the tendency of recent research on (im)politeness in healthcare settings to move beyond an uncritical use of Brown and Levinson's (1987) seminal Politeness Theory and to draw on other theoretical frameworks, such as relational work (see also Graham 2009). Although Politeness Theory remains one of the most popular frameworks, in more recent research, it is often used a starting point or general frame of reference which is then further supplemented and extended by other theoretical approaches (e.g. Harrison and Barlow 2009; Rhys and Schmidt-Renfree 2000). One of these 'other' concepts often used in combination with Politeness Theory in research in the healthcare context is the notion of Community of Practice (Wenger 1998). In line with the community of practice approach, the frequent face attacks by the nurses in the Kenyan hospital that Ojwang et al. (2010) observed, for example, can at least partly be understood as a reflection and enactment of some of the licensed and normative practices that have emerged among the nurses in this hospital setting. The authors argue that, while this kind of confrontational face-attacking behaviour may be perceived as impolite and inappropriate by the patients (who are outsiders to this particular community of practice), it may be interpreted as completely normal, appropriate behaviour by the nurses (who are integral members of this particular community of practice).

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The theoretical and methodological differences in research orientations also surface in the use of different data. Research conducted within communication studies and medical anthropology tends to gather data via experimental designs around hypothetical scenarios (often with students as participants) (e.g. Bromme et al. 2012; Dillard and Shen 2005; Jenkins and Dragojevic 2013; Pitts et al. 2014) or survey questionnaires (e.g. Bartlett and Coulson 2011), and often uses a five-point Likert scale or other kinds of descriptive statistics to analyse frequencies and correlations of particular behaviours. However, within applied linguistics and pragmatics, most research studies on (im)politeness in healthcare contexts are data-driven and draw on qualitative sociolinguistic methodologies, such as discourse analysis (e.g. Grainger 2004; Grainger et al. 2005; Zayts and Schnurr 2013; Graham 2009). This include both written documents (such as the critical incident reports in Iedema (2005)), spoken interactions (such as the face-to-face conversations recorded by, for example, Zayts and Kang (2009) and Grainger (2004)), as well as a range of online material (e.g. Gallardo and Ferrari 2010; Oh et al. 2012; Locher 2006; Thurnherr et al.

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2016). Other popular methods of gathering data employed by researchers across different disciplines include participant observation (e.g. Mason 2004; Ojwang et al. 2010), conducting interviews (e.g. Pliskin 1997; Brashers et al. 2006), and organising focus groups (Woodhead et al. 2006).

While dealing with naturally occurring interactional data may be relatively challenging, not least due to a range of ethical issues that may arise as pare of obtaining patients' informed consent for participating in the research, the studies briefly reviewed here clearly indicate several major advantages of such an approach. In particular analysing authentic data is central to the endeavor of gaining a better understanding of how notions of (im)politeness are actually enacted and negotiated among participants in specific encounters in the healthcare context.

3. Critical overview of research: Illustrating emergent themes of relational work in health contexts

The previous section presented a succinct overview of the scope of past and current (im)politeness research and briefly couched on the topics of e-health, culture, and theory and method. In this section, we will revisit these concerns with the help of some data. Our discussions of examples from several different health contexts, including an American health advice column for university students, reflective writing texts form medical students in the UK, and
telephone counselling calls between genetic nurses and mothers of newborns in a Hong Kong hospital, are guided by the attention to a number of themes that re-emerge in the health literature discussed above and that are of special interest to interpersonal pragmatics:

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- the face-threatening potential of many interactions in a health context;
- the negotiation of roles pertaining to health interaction in dynamic encounters;
- the creation and maintenance of trust and expertise;
- the importance of counselling, providing advice, providing information, etc.

These themes areas are fundamentally linked to face concerns and to each other. A number of examples of naturally occurring data serve to illustrate these claims.

The face-threatening character of many health encounters has been documented in many studies. The face-threat can be due to taboo issues, such as reported in Silverman et al.'s (1992) work on AIDS/HIV counselling, or may be due to concerns of social control and perceived differences in expertise, such as in Heritage and Sefi's (1992) studies on health nurses who visit first time mothers. Both studies report on patterns of counselling and advice-giving that pay tribute to the delicate nature of the issues at hand, i.e. the sexual taboo topic and the potential implication that the mothers are not doing their job well. In Grainger et al.'s (2005, p. 35) study on delivering bad news, they show how patient and therapist 'collaboratively manage the emergent "bad news" situation.' Sarangi and

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Clark's (2002) work on genetic counselling also reveals to what extent the parents expect advice while the counsellors are not allowed by their institutions to take a personal, advisory stance. As a result, the roles of experts and clients are contested and negotiated, which entails the risk of face-loss.

In the case of health encounters, notions of trust and expertise are particularly relevant (cf. Sillence 2013; Armstrong et al. 2011). In Locher's (2006, 2010) study of an American health advice column for university students, the team of health professionals create a fictional, female advisor persona and develop a voice for her that is supposed to be both attractive (e.g., displaying a sense of humour) and informed (e.g., referring the readers to expert sources and using a moderate amount of medical jargon, which is then explained for a lay readership; see also Locher and Hoffmann 2006). The success of this professional health advice column 'Lucy Answers' lies in attracting a readership that returns to the columns regularly and dares to ask (sensitive) questions.

The study of how advice is rendered reveals that there is a complex interplay of relational work strategies on different levels. The team hardly ever starts a response to a question with an advisory move; instead, the advisory passages are embedded within discursive moves such as assessing the questioner's situation, giving general information on health concerns or explaining raised issues in more detail. In this, the composition of the response letters resembles a stepwise entry to advice, similar to the face-to-face context of health nurses advising first time mothers mentioned above (Heritage and Sefi 1992). Furthermore, the advisory passages show sensitivity to face concerns by formulating advice in the form of declarative sentences and questions as in (1) and (2); however, next to this general orientation to mitigation and face-saving, we also find advice in the form of imperatives as in (3) (all examples are taken from Locher 2006).

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(1) You might try the 'Stop-Stare' method. (a declarative sentence realizing a suggestion)
(2) Why not crank 'Under The Table And Dreaming' the next time your boyfriend is over? (an interrogative inviting a future action)
(3) Discuss this with your health care provider [...]. (an imperative as directive)

However, in 'Lucy Answers' imperatives on their own or in the form of lists are embedded within the entire response letter and can thus be argued to be already mitigated to a certain extent. They often function as suggestions for several possible courses of action or for action sequences (Locher 2006, pp. 98-101).

Furthermore, the advisor 'Lucy' uses face-enhancing involvement strategies by praising the questioners about their behaviour and commending actions that they described, as well as bonding and empathising with the questioner (examples 4 to 6).

(4) Kudos to you for seeking help.
(5) Good luck with your investigation
(6) It's not at all uncommon to experience some degree of anxiety when you move, change jobs, graduate, get married, etc. – even if these big life events are positive ones.

Published in: doi.org/10.1057/978-1-137-37508-7_26

In contrast, we also found face-aggravating strategies in the data in the form of criticism of the questioner or boosting the advisor's expertise.

(7) It isn't good to smoke no matter what else you do.

(8) It is essential to talk with your health care provider and/or pharmacist about your prescription [...].

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All of these strategies together make up the relational work in this particular health practice, so that, while mitigation is clearly dominant, face-enhancing and face-threatening behaviours also have their place.

Concerns about expertise and trust also surface in reflective writing texts written by medical students in the UK (Locher 2015b, 2017). The students, who were asked to write about a memorable encounter with a patient during their attachment/internship, rarely wrote about politeness explicitly; however, they did comment on identity management and in particular on their fears to appear unintentionally rude or impolite in the eyes of their patients. In example (9), a student reports on such a situation as follows:

(9) The first thing that struck me was that the patient sort of mumbled when speaking due to his illness. This made the encounter tricky, but also rather *awkward* for me as I *wasn't sure* whether to keep asking him to repeat things or just nod in a clueless manner. *After all, the last thing I wanted to be was rude,* and unfortunately this played on my mind throughout the interview. (italics added)

In this excerpt, the student describes his emotional involvement and thus highlights the interpersonal consequences of his action or inaction (on the link between emotions and relational work see Culpeper 2011; Locher and Langlotz 2008; Langlotz and Locher 2012, 2013, in press; Locher and Koenig 2014; Spencer-Oatey 2007, 2011). In addition to emotions, other themes that appear in the corpus (*N* = 189) are the importance/value of the creation of rapport between the provider and patient, the important role of empathy, the presentation of self when claiming the status of a medical student and future health provider, the challenge of finding the right level of relational work, and the interpersonal consequences of communication styles/choices on relationships. Concerns like these, raised by medical students, can provide useful additions to the medical communication skills curriculum, need to be addressed in courses on communication skills, and may also help sharpen our analytical tools for interpersonal pragmatics.

Some of these concerns are also reflected in spoken medical interactions. We have chosen one example here from a larger corpus of genetic counselling sessions (for more details see Zayts and Schnurr 2014) to illustrate how some of the overarching themes identified above pan out in spoken encounters between healthcare professionals and clients. The example that we analyse below is taken from a corpus of audio-recorded telephone consultations between genetic nurses in a neonatal screening unit at a specialist

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genetic clinic in Hong Kong and mothers of newborns who have been diagnosed with G6PD deficiency, which is a mild hereditary condition that can be managed by taking certain preventative measures (see Zayts and Schnurr 2017). These telephone conversations, which typically take place while the mother is still on the maternity ward, are aimed at informing the mothers about their baby's diagnosis and advising them on preventative measures to be taken after their release from hospital. ↑ 700 701 ↓

The activities of telling a mother how to manage her newborn's condition and advice giving are potentially face-threatening as they could be perceived by the mothers as an intrusion into their area of expertise (i.e., how to look after and take care of their baby; compare Heritage and Sefi 1992). Due to the potentially face-threatening nature of these interactional activities, these telephone consultations are thus interesting sites for an analysis of several issues pertaining to (im)politeness in medical contexts. This is particularly true for those interactions that involve mothers who have some prior knowledge of the condition, as illustrated in (10), taken from Zayts and Schnurr (2014). This example, which we have chosen for closer scrutiny here, involves such a 'knowledgeable' mother, i.e. a mother who has some prior knowledge of the condition (in this case, because she has it herself). As a consequence of the mother's knowledge, she interrupts and to a certain extent rejects the nurse's attempts at delivering information and giving advice, thereby challenging the nurse's face, as well as the authority and expertise associated with the nurse's professional role.

(10) Telephone conversation between a nurse (N) and a mother (M) whose newborn has recently been diagnosed with G6PD. Since M also suffers from the deficiency herself, she has some prior knowledge of the condition which she informed the nurse about earlier in the conversation. The exchange took place in Cantonese, the native language of both interlocutors.

1. N: ***所以,*** *要預防嘅****話,*** *嗷****呀:, (.) 媽咪,***
   頭先你講過啦有大部份*嘅****中藥****喺唔可以食.***
   *嗷****呀,(.)其實呢主要就****喺五種****[中藥要避免****].*
   Therefore, in order to prevent, so:, (.) mommy[1], you have mentioned earlier that most Chinese medicine cannot be taken by him. So, (.) actually there are mainly five types [of Chinese medicine to avoid].
2. M: *喺.* ↑ 701
   Yes.
3. N: *喺啦. 嗷呀, 你記唔記得喺邊五種呀?* 702 ↓
   Right. So, can you recall what are these five types?
4. M: 唔記得.

[1] The terms 'mommy' and 'daddy' are frequently used in the Hong Kong data by the medical providers when addressing their clients. It thus seems to be normal and acceptable practice (and hence politic behaviour), which could perhaps be interpreted as a way of building rapport and doing relational work.

Published in: doi.org/10.1057/978-1-137-37508-7_26

I don't remember.

5. N: 唔記得? 嗱, 噉, 我, (.)

   You don't? Mm, so, I, (.)

6. M: 單張嗰到有無㗎？

   Does the leaflet contain this information?

7. N: 單張呢有嘅, 不過, 不過如果問媽咪, 你, 你自己點樣做呀?

   The leaflet contains the information, but, but if I ask mommy, you, how would you yourself act?

8. M: 誒:.

   Eh:.

9. N: 即係你, 自己本人呀, 因為你知你有呢個病, 㗎嘛？

   As in you, you yourself, because you are aware that you have this deficiency, right?

10. M: 我, 我, 我知道邊啲唔食得或者唔好接觸. (.)

    I, I, I know what cannot be eaten or touched. (.)

11. N: 噉呀, 誒: 譬如, 嗱, 因為你頭先話你又唔記得咗邊啲中藥唔食得啦, 噉樣如你=

    So, eh: for example, nah, because you said earlier that you have again forgotten the types of Chinese medicine which cannot be taken, so what if you=

12. M: =所以我咩中藥都唔食囉.

    =So I do not take any Chinese medicine lo.

The nurse's questions in turns 1 and 3 which aim to assess the mother's knowledge of G6PD are relatively directive and almost condescending, and hence potentially face-threatening – especially since the mother has previously informed the nurse that she has the condition herself and knows how to manage it (not shown here). Against this background, the nurse's information delivery seems strictly speaking unnecessary (as the mother presumably knows what kinds of medicines she and her baby are allowed to take), and the nurse's question in turn 3 could be understood as implying that the mother may not actually have this knowledge and could thus be face-threatening. The mother seems to interpret the nurse's behaviour in that light, as is reflected in her responses. Although she admits that she does not remember the information (turn 4), she subsequently resists the nurse's attempts at information delivery, for example by interrupting her and asking whether this information is also included in the leaflet that all affected mothers receive prior to the telephone
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consultation (turn 6). The relative directness of the mother's question indicates her resistance to the nurse's attempts at information delivery and at the same time also challenges the nurse's face and delegitimises her institutionally assigned role as information provider (see also Zayts and Schnurr 2017). This continues throughout the interaction, for example when the mother categorically states her knowledge about which substances to avoid instead of answering the nurse's request for information (turn 10).
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Thus, in order to continue with the information delivery, which constitutes a crucial aspect of these counselling interactions (Zayts and Schnurr 2014), the nurse employs several strategies to negotiate the roles of interlocutors while at the same attending to her own face and that of the mother. For example, she continues to try and provide information in spite of the mother's resistance by asking questions to encourage the mother to cooperate (turns 7 and 9) and by providing explanations for her own behaviour (e.g. turn 11). But in spite of the nurse's efforts, her attempts are in vain and she does not manage to deliver the information in this exchange – rather, at the end, the mother interrupts her again with yet another categorical statement (turn 12). With this face-threatening behaviour she once more challenges the nurse's role and authority. This behaviour is quite typical for encounters with 'knowledgeable' mothers in which the mothers frequently question the traditional dichotomous role allocation according to which the healthcare professional is set up as the expert and the mother/client is constructed as the (less knowledgeable) lay person (see also Zayts and Schnurr 2017).

Coming back to the re-emerging themes described above, our analysis of this example of spoken interaction has shown that because advice giving, information delivery and other potentially face-threatening activities are crucial aspects of many medical encounters, interlocutors are constantly engaged in doing relational work and, closely related, negotiating their own and each other's roles and responsibilities. These processes take place throughout an interaction, and provide further support for claims that there is no one single or best way of giving advice, delivering information, doing counselling etc.; rather, what are considered to be appropriate and politic ways of performing these activities is dynamically negotiated among interlocutors as their interaction unfolds.

4. Conclusions and future directions for research

Looking at the studies that elaborate on issues that are of interest to (im)politeness scholars who work on health contexts, we need to first reiterate that many relational concerns crucial to health contexts are not necessarily
discussed with an (im)politeness approach. However, if we take a broader perspective, adopting an interpersonal pragmatic lens (see Locher and Graham 2010, p. 2; Haugh et al. 2013, p. 9), we can fruitfully explore concerns that have been discussed under the terms facework, rapport management, or relational work by different authors in the health context. It is not surprising that this context yields such challenging and rich data since interactions between the parties in question (health professionals, caretakers, patients) involve intricate negotiations of differences in power, dependency, expertise, and trust, often in contexts where delicate and in some cases life-threatening concerns are deliberated. There are thus dearly several avenues for future research, and we would like to suggest the following list as possible first steps towards exploring the incredibly complex and diverse topic of (im)politeness in healthcare settings:

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- As in so many research areas in applied linguistics, it seems to us that there is a dominance of studies on health practices in English. More research from an interpersonal pragmatics perspective on other languages is thus called for to shed further light on how people in other, often marginalized and overlooked sociocultural contexts deal with the various challenges of health communication (e.g. Hernandez Lopez 2011; Vickers et al. 2015). There is also dearly a need for more intercultural and intracultural studies – especially those that embrace recent critical conceptualisations of culture and move beyond cultural stereotyping and instead focus on actual practice.
- In a similar vein, further research is needed to explore health contexts in which the providers and patients do not share the same language(s). Linguistic problems occur both when the providers do not speak the local language of the patients (this is the case in many countries where the doctors and nurses are foreigners due to a dearth of professionals), and in settings where immigrants do not speak the dominant local language, as well as in multilingual contexts where both parties are not proficient in each other's language or a lingua franca (e.g., Mason 2004; Zayts and Kang 2009; Vickers et al. 2015). These situations are challenging on the transactional, informational level as well as on the interpersonal level (e.g. do the patients dare to insist that they have not understood an explanation or an instruction? How do the providers make sure that instructions are understood?). Due to globalisation and continuing migration trends world-wide, these issues become increasingly more relevant and thus demand more (applied) research – especially, since local (im)politeness practices may not be known by those 'new' to the context, and neither may their in-context values. ↑ 704
- More studies on health practices in computer-mediated contexts will help to reflect the changing landscape of healthcare which increasingly taps into this medium/ channel to communicate with potential and actual patients and clients, their families, professionals and the wider public (Prestin and Choud 2014). It seems to us that a combination of approaches from rhetoric, argumentation theory, identity construction and (im)politeness frameworks might be particularly fruitful for the study of public health sites that deal with persuasion and risk management (e.g. Rudolf von Rohr 2015). Moreover, the potential of lay sites for health support and advice-giving deserves further attention (e.g. Sillence 2013), and the potential of CMC for emotional and psychological counselling is dearly booming so that we can expect to see more studies in this field. 705 ↓
- From a methodological point of view, we see that many applied linguistic and pragmatic studies in the area of (im)politeness in healthcare employ purely qualitative methodologies. While dearly recognising the value of this research, we would also like to call for more quantification and an increased use of mixed methodologies (cf. Locher 2015a), which, we believe, can help in establishing patterns that illustrate the norms of (im)politeness practices.
- Finally, on a more abstract level, we believe that the medical/health humanities, with their concerns ranging from teaching communication skills to medical students to

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narrative medicine in general, provide a challenging and worthwhile interface with our interests that is worth exploring. For example, the creation of rapport and empathy, learning how to 'listen', and how to interpret patients' narratives etc. coincide with the interest of (im)politeness scholars concerned with interpersonal pragmatic issues, such as norms of conduct, identity construction and the negotiation of face (e.g. Gygax et al. 2012; Gygax and Locher 2015; Locher et al. 2015; Locher 2015b, 2017; Silverman et al. 2013).

For these various areas of research that we have briefly outlined here, we believe that combining the study of identity construction and role negotiation together with face concerns (Hall and Bucholtz 2013, p. 130; Locher 2008; Spencer-Oatey 2007; Schnurr and Chan 2011; Zayts and Schnurr 2014) is a promising way forward as it allows us to identify and better understand the strategies through which face is negotiated while at the same time linking these insights to the ways in which interlocutors dynamically maintain and reinforce, as well as challenge and change interactional as well as (im)politeness norms.

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Acknowledgements

Part of the research reported in this chapter was supported by a grant from the Hong Kong Research Grants Council of the Hong Kong Special Administrative Region, China (project no. HKU 758211 H). We are grateful to the participants of this project who allowed us to record their interactions, and the other members of the research team Dr Olga Zayts, Dr Lam Tak Sum Stephen, Dr Lo Fai Man Ivan, and Ms Fung Shun Mei May, as well as the research assistants Yau Hoi Ying Alice and Cheuk Kwok Wing Natalie for assistance with transcribing the data. Furthermore, we thank the Swiss National Science Foundation for supporting the work on the project *'Life (beyond) writing': Illness narratives* (CR13I1_126959; CR13I1_144541) and *Language and Health Online* (100016_143286/1).

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