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醫病溝通中之協商：以北台灣之眼科醫師為例

Politeness in Medical Communication: A Study Based on an Ophthalmology Clinic in Northern Taiwan

許學旻

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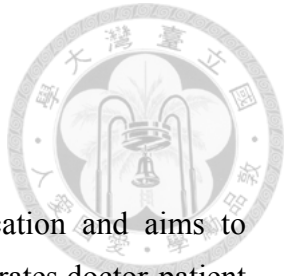

Abstract

This study investigates face-to-face doctor-patient communication and aims to provide a linguistic viewpoint of doctor-patient relationships. It illustrates doctor-patient communication as a negotiated and co-constructed process between the doctor, patients, and patients' companions. Due to their power asymmetry, the participants use different politeness strategies to achieve their communicative goals. When the patients' companions are present, the consultation is more complex.

Researches related to doctor-patient communication have increased in the past few decades in the West. Medical education and system in Taiwan have also adapted accordingly. Studies have shown that communication between doctors and patients is influenced by their institutional power asymmetry. From a doctor's point of view, the purpose is to provide the best medical treatment for the patients. On the other hand, patients want to choose their preferred treatments. The doctor and patient parties exchange information and reach their decisions through communication.

In this study, we analyze qualitatively how the doctor, the patients, and their companions co-construct communication during their negotiations. This research is conducted in an eye clinic in a medical center in Northern Taiwan. There are in total 45 patients (16 males and 29 females), and 5 companions (2 wives, 1 husband, 2 daughters, and 1 son) in this study. We explore the data by referring to Brown and Levinson's (1978) politeness model, specifically bald recommendations, collaborative plural, and hedges under Taiwanese social and cultural factors. During the consultations, when the participants give advice or make requests, they try to protect each other's positive or negative faces. If the family companions join the consultation, they may raise questions or make requests for the patients. The consultation is different depending on the participants involved.

This research shows how the power asymmetry between the doctor and patients affects the way they use politeness strategies to achieve their communicative goals. Finally it also allows us to understand the importance of doctor-patient negotiation to create more equal and harmonious doctor-patient relationships in Taiwan.

Keywords**:** medical discourse, doctor-patient communication, doctor-patient-companion communication, triadic medical communication, politeness

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Chinese Abstract

本研究主要關注於醫病溝通間醫師、病人與陪同者相互協商與共同建構的溝通過程。由於權力的不同導致在看診時，參與者為了達到各自的溝通目的而使用不同的禮貌策略，當有陪同者在現場時，會使問診過程更加複雜。本論文希望藉由臨床上實際醫病溝通的語料，提供一個增進醫病關係的切入點，從語言學觀點探討增進醫病溝通的可能。

醫病溝通相關研究在西方已蓬勃發展數十年，台灣的醫學教育與體系也是承襲西方醫學，然而，醫病問診中因為醫師與病人地位不平等或是權力的拉鋸，是影響醫病溝通的因素。在醫師的角度，希望能給予病患最好的治療，並增加病人遵醫囑的接受度，對於患者而言，他們想要選擇偏好的治療，或是對於病況有疑問能得到解答，雙方透過溝通來達到交換資訊與達到共同決策的目的。

本研究採用質化的方式分析語料，藉由醫病與陪同者間一步步共同構築而成的協商來探究參與者實際的溝通目的，本研究在北部一間醫學中心的眼科門診執行，總共有 45 位患者參與本研究，16 位男性，29 位女性，陪同者共有 5 位，2 位妻子、1 位先生、2 位女兒與 1 位兒子。在台灣的社會與文化背景中，從 Brown 及 Levinson (1978)的禮貌模型出發，著重在三個禮貌策略：直接提出要求、使用第一人稱複數來涵蓋所有參與者、避免正面回答，因為在問診過程中，參與者在給予意見與提出要求時，會為了要保護對方或自己的正反面子而會有所調整。若陪同者加入，他們會替病人問問題或是提出要求，整個問診過程會因為角色與溝通目的的不同而有所改變及調整。

本研究的目標是希望能呈現醫師與病人因為權力不平等，進而影響他們為了達到溝通目的時所使用的不同禮貌策略，透過實際語料的分析，加上台灣特殊的文化背景，提供醫療服務人員與患者一個不同的視角，從語言學的角度剖析醫病協商的現況與重要性，以期在未來達到更平等更和諧的醫病溝通與醫病關係。

關鍵字：醫病言談、醫病溝通、醫師病人陪同者溝通、醫病三方溝通、禮貌

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Transcription Conventions

[ ]	Beginning and ending of overlap in speakers' utterances
?	Upward intonation
CAPITALS	Relatively high amplitude (in Mandarin transcription: **bold**)
/ /	Encloses description of how talk is delivered
_____	Code-switching (e.g. Taiwanese)
=	Latching
..	Short pause
…	Long pause
[…]	Text omission

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Chapter 1. Introduction

This study examines doctor-patient communication as a negotiated and co-constructed process between health providers, patients, and patients' family members. Studies from Western countries have revealed that an open communication can improve the quality of health care, the patients' compliance, and both the doctors' and patients' mental health (Ong et al., 1995; Maguire and Pitceathly, 2002). It also allows patients to express their concerns and medical preferences (Charles et al., 1999; Makoul and Clayman, 2006). Many doctors in Southeast Asia receive their medical education through a Western system (Claramita et al., 2011), following the curriculum of Western medicine schools. Studies have shown that in Southeast Asian settings both doctors and patients favor the egalitarian communication style (Haviland et al., 2005).

When under a specific clinical context, doctor-patient communication is influenced by the power asymmetry between the participants. Because of the asymmetry between doctors and patients, patients tend to respect doctors and not challenge their authority in order to maintain harmony during medical consultation. Their communication is examined as a tool for rapport and solidarity (Kuipers, 1989; Tannen, 1990).

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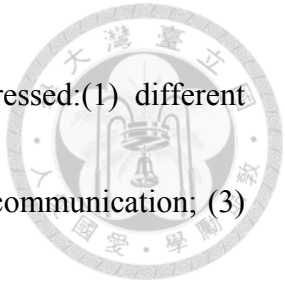

In Medical communication, some topics are commonly addressed:(1) different purposes of medical communication; (2) analysis of doctor-patient communication; (3) specific communicative behaviors; (4) the influence of communicative behaviors on patient outcomes; and (5) concluding remarks (Ong, 1995). Most studies focus on doctor-patient relationships only. However, patient's companion (e.g. spouses, family members, friends) as a third party influence the doctor-patient relationship (Keady and Nolan, 2003; Ishikawa et al., 2005; Karnieli-Miller et al., 2012). Besides, the different visits, companion roles, and the companion involvement are the factors to change the dynamic of the consultations. The companion may limit the patient's involvement or even exclude the patient from the decision-making (Coe and Prendergast, 1985; Beisecker , 1989; Greene et al., 1994) or can benefit the doctor-patient communication and increase patient's comprehension and involvement compared with the unaccompanied patients (Clayman, 2005; Labrecque et al., 1991; Prohaska and Glasser, 1996; Schilling et al., 2002).

The growing studies examine the involvement of patient's family companions to the medical consultations (Wolff and Roter, 2011; Laidsaar-Powell et al., 2013; Wolff et al., 2017). But the focuses are mostly on the specific doctor-patient-companion

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communication on the elderly or cognitively impaired patients (Smith and Beattie, 2001; Werner and Kitai, 2004; Zaleta and Carpenter, 2010; Sakai and Carpenter, 2011; Karnieli-Miller et al., 2012), or on doctor-parent-child communication (Tannen and Wallat, 1983; Aronsson and Rundström, 1988; Van Dulmen, 1998; Tates and Meeuwesen, 2001). In the United States, over one-third of elderly patients have a companion when seeing the doctors (Wolff and Roter, 2008). In Taiwan, there are already some researches related to the triadic doctor-patient-companion communication. For example, the companion's participation can influence the patient parties' information providing sequences (Tsai, 2007b). And the opening stage in medical encounters in Taiwan is very different from the western style because of the time limits and replaced by situational greeting instead (Tsai, 2005). Another study focuses on the verbal and nonverbal triadic interaction in Taiwan, the spatial arrangement of patient companions in geriatric triadic medical consultations can reflect the patient's role in the medical consultations and the relationships with their family companions (Tsai, 2007a). The present framework for analyzing the third party's participant may not be suitable for Mandarin and Southern Min, Tsai (2003) identifies the problems when identifying the participant structure in medical triadic consultations in Taiwan and provides some

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solutions when examining the companion's participation.

Tsai (2000) proposed a systematic framework to analyze the companion's participation. One of the results shows that the companion's interruption does influence the communication between the doctor and the patient. Even though most of the patients are the main information providers, it is hard for them to complete their responses when both the patient and the companion are talking.

Instead of studying the patterns, participants' involvement, or patient's satisfaction in medical discourse, we try to analyze medical communication in a different domain, the idea of politeness. Previous study applies politeness strategies to doctor-patient communication to study the collaborative thinking of the doctor and patients (Aronsson & Sätterlund-Larsson, 1987). The other study focuses on the politeness and coherence in pediatric discourse to see how discourse is continuous negotiated between participants (Aronsson & Rundström, 1989). The politeness model proposed by Brown and Levinson's (1978) is universal and with examples from different societies and cultures. But when under the specific cultural and social context, will participant's politeness strategies be affected? Especially when the participants in medical context are with great power asymmetry, their communication is more complex because of the

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social factors. Thus, we conduct our study in one medical center to understand the communication the discourse between doctor, patient, and patient's family companion in order to understand the politeness strategies they used when making requests or demand or showing medical preferences in the medical decision-making. Three politeness strategies are mainly discussed in our study: (1) bald recommendations, (2) collaborative plural, and (3) hedges. The process of how communication between doctor and patient parties is negotiated and co-constructed is studied under politeness within the social and cultural background in Taiwan.

1.1 Motivation

A growing interest in doctor-patient communication has arisen during the past few decades. Many studies have investigated the communication of medical consultations. However, the results from those studies have not yet shown the whole picture of medical communication, probably due to the fact that among interpersonal relationships, doctor-patient relationship is one of the most complicated ones. The interaction between doctors and patients involves various power status, and is usually related to vital or

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health issues, influenced by emotions and needed cooperation and negotiation (Ong, 1995; Chaitchik, 1992).

The doctor-patient relationship can be categorized into four models: (1) informative model; (2) interpretive model; (3) deliberative model, and (4) paternalistic model (Emanuel and Emanuel, 1992). Among these four models, the paternalistic model, also known as parental or priestly model, is the most prominent one. (Emanuel and Emanuel, 1992; Levine et al., 1992; Beisecker and Beisecker, 1993; Deber, 1994; Coulter, 1997). The paternalistic model assumes that patients could receive the best medical advice and treatment decision from doctors to improve their health. This model is based on the assumption that both doctors and patients have mutual objective criteria for defining the best outcome. However, the fact is that most patients lack equal medical knowledge to discuss their health problems with doctors under medical circumstances. (Waitzkin and Waterman, 1974; Fisher and Groce, 1985).

According to Waitzkin and Waterman (1974), and Henley and Henley (1977), doctor-patient interactions are social and micro political. Interactions are shaped and constrained in cultural, structural and institutional features. Furthermore, the two parties are not equal partners during their interaction since doctors have more medical

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knowledge while patients usually do not. During the consultation, doctors are regarded as the gatekeepers to control the process. This asymmetry leads doctors to take superior roles while patients are perceived as subordinates.

Due to the disadvantages of the paternalistic model, that is the unequal status between doctors and patients, patient-centered communication has been emphasized greatly for decades. Patient-centered communication provides an environment for patients to fully express their symptoms, feelings, concerns, and expectations during consultation (Henbest and Stewart, 1989; Smith and Hoppe, 1991; Roter et al., 1988). The main idea of the patient-centered method is "to follow patient's leads, to understand patient's experiences from their point of view" (Weston et al, 1989), allowing the doctor-patient relationship to become more equal and egalitarian. In addition, their relationship would be empathic. This means that doctors would elicit patients' feelings and respond accordingly, remain silent to show support, listen carefully and try to understand what they are unable to express, and provide support orally as well as nonverbally (Lovett and Abou-Saleh, 1990; DiMatteo et al., 1980). In fact, patient-centered communication is shown to have improved patients' health (both physically and mentally) and have increased the efficacy of health care and compliance

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(Oates et al., 2000; Stewart, 2001; Epstein et al, 2005). The health care providers nowadays try to follow the principles of patient-centered care in order to create a better relationship with patients.

1.2 Research Questions

Previous studies in medical discourse mainly examine through turn-allocation constraints to analyze doctors' and patients' participation (talking frequently or raising questions) or through conversational constraints to study institutional authority. The present study aims to examine the communication in medical consultations through politeness constraints. In order to understand how communication is negotiated and co-constructed under the asymmetry between doctors and patients in an institutional authority structure, the research questions are:

1. What linguistic strategies are used in the negotiation of doctor-patient medical decision-making to save each other's faces?
2. In the triadic medical consultations, what linguistic strategies do the three parties apply in medical decision-making process while saving each other's faces?

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1.3 Organization of the Thesis

The rest of the paper is structured as follows: Chapter 2 provides a quick review of the related studies and basic ideas of medical communication, politeness, and power. Chapter 3 contains the methodology used in this study, how the data is collected and transcribed, the theoretical background and the analytical framework. In Chapter 4, there are data and analyses of the politeness strategies used between two parties and three parties during the medical consultation. The idea of politeness drawn from Brown and Levinson's (1987) politeness model. The main focuses are three politeness strategies: (1) bald recommendations, (2) collaborative plural, and (3) hedges. Some of the politeness strategies used by the participants are also discussed in the excerpts of the consultations. Finally, Chapter 5 summarizes the major findings in the study and provides suggestions for future studies.

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Chapter 2. Literature Review

The study of language and doctor-patient relationship has drawn wide attention and interests from cross-disciplinary researchers. Medical discourse provides insightful data for us to understand the role of language in doctor-patient communication. It offers first-hand data for analyzing the functional meaning of the utterances in medical encounters since language is regarded as the vehicle of meaning. Medical encounters are ideal for understanding institutional talk by investigating the imbalance of power between doctors and patients and the outcome of their talk. In this chapter, we will discuss previous studies related to sequential phases of medical consultation, medical decision-making (mutual persuasion process), the power asymmetry between doctors and patients, and how medical discourse is shaped by politeness.

2.1 Doctor-patient Communication

Medical consultation is one of the institutional talks that is ritualized and can be studied by its fundamental organization – sequential phases (Helman, 1984). The ritualized phases model has been applied for analyzing medical encounters and the

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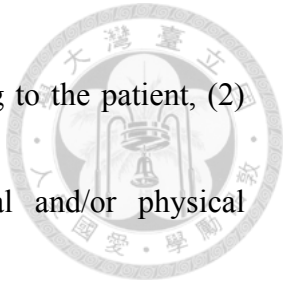

consultation is suggested to be composed of six phases: (1) relating to the patient, (2) discovering the reason for attendance, (3) conducting a verbal and/or physical examination, (4) considering the patient's condition, (5) detailing treatment or further investigation, and (6) termination (Byrne and Long, 1976; Waitzkin, 1991, Heath, 1992). Ten Have (1989) generates a general 'ideal sequence' for the consultation which brings together the three dimensions of medical consultations: sequential phase, its discourse genre, and major speech activities. The sequence contains 6 phases: (1) opening, (2) complaint, (3) examination or test, (4) diagnosis, (5) treatment or advice, and (6) closing.

The cases of the study in the NTUH ophthalmology department mostly follow the 6 phases. The time period from (1) opening to (3) examination phase is relatively short. The doctor and the patients spend more time discussing about (4) diagnosis and (5) medical treatments. Sometimes, when the patient is still being examined (facing an ocular slit lamp), the doctor gives the diagnosis and they start to discuss about the causes of the disease or further treatments.

Doctor-patient communication can be regarded as the process of mutual persuasion. The study of persuasion could be traced back to ancient Greece, where the term

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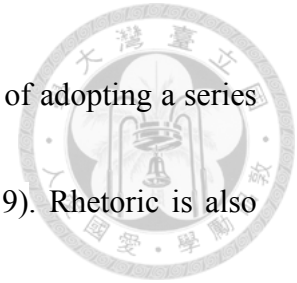

"rhetoric" was used (Brake, 1969; McKeon, 2009). It is the process of adopting a series of symbols to induce cooperation (Brock, Scott, & Chesebro, 1989). Rhetoric is also defined as people persuading each other to make free choices (Hunt, 1955), and the process of persuasion through rhetoric view is conveyed by discourse. One's utterances carry the information that would influence the other's decision. In doctor-patient communication, the persuasion is mutual. Doctors provide information to influence patients' decision-making. At the same time, patients also try to influence doctors' medical choices for them, because they may want to have certain prescription or medical treatment. In other words, medical communication is a persuasive process that both doctors and patients are involved in and take the roles of persuader and persuadee (Smith and Pettegrew, 1986). The mutual persuasion between doctors and patients demonstrates the shared and negotiated decision-making.

Though decision-making is negotiated by doctors and patients, doctor-patient communication is mainly doctor-initiated. During consultation, doctors actively ask patients' symptoms and prescribe medications for them. And because of their unequal medical knowledge, patients could only understand their disease through doctors' judgment and explanation. Doctors are regarded as the one with authority and power. In

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fact, the study of power and domination and effective communication in medical encounters has been emphasized greatly since the 1960s (Lupton, 1995). The power doctors have during consultation was regarded as the aid to assist patients to make better medical choices and gain compliance. Doctors were expected to not only listen to patients but also to avoid the communicative gaps or obstacles during communication. But the doctor-patient communication is in fact a process of mutual persuasion; though with less medical knowledge, patients strive to "equalize the balance of power or gain and maintain control over aspects of their healthcare" (Beisecker, 1990). When in patients' expertise (symptoms, preferences, concerns), they should take responsibility of their health condition, and be encouraged to ask questions or be able to choose or refuse different medical treatments. Hence, the patient is "empowered" during consultation (Lupton, 1995).

2.2 Politeness

Brown and Levinson (1978) proposed a general model of politeness and showed how discourse is shaped by politeness in different cultures and societies. The idea of "face" from Goffman (1967) claims that people's interaction is the cooperation of

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maintaining each other's face. From their point of view, everyday discourse contains many face-threatening acts (FTAs) like critiques and requests. From Brown and Levinson's (1978) definition, the face is separated into (1) negative face: the want to be unimpeded by others, and (2) positive face: the want to be desirable and close to others. There are two distinctions of FTAs. The first one distinguishes acts that threaten the hearer's negative or positive face. Acts that threaten the hearer's negative face are those in which the speaker impedes the hearer's action, such as: requests, suggestions, promises (e.g. the speaker commits a future action that benefits the hearer, and the hearer is under pressure to accept or reject it) and compliments (e.g. the speaker shows desire in the hearer's possession, so the hearer might feel like he has to give it to the speaker), etc. Conversely, acts that threaten the hearer's positive face are those in which the speaker disregards the hearer's wants, like: criticism, complaints, and disagreements. However, there may also be an overlap in the distinctions of FTAs because some of them threaten both the negative and the positive face, such as complaints and interruptions. The second distinction focuses on acts that threaten the speaker's negative or positive faces. Because the speaker and the hearer work together to maintain each other's faces, the acts in the second distinction may threaten the hearer's face as well.

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Acts which threaten the speaker's negative face include: expressing thanks (make humble the speaker's own face), acceptance of offers (the speaker is indebted and threatens the hearer's negative face), and making unwilling promises and offers (the speaker is against his own will to commit to future actions, and it threatens the hearer's positive face if the speaker's unwillingness is perceived). Other acts that threaten the speaker's positive face are: apologies (the speaker regrets doing an FTA), acceptance of a compliment (the speaker may have to be humble or compliment the hearer in return), and confession of guilt or responsibility.

In Brown and Levinson's (1978) model, the possible strategies for doing FTAs are proposed (See Figure 1). If a speaker goes on record, his action and communicative intention are clear to the participants. For example, if a speaker says, "I promise to come tomorrow" and all the participants have the idea that the speaker clearly commits himself to be here tomorrow, this unambiguous intention is considered as "on-record". On the other hand, off record is when the speaker's communicative act has more than one intention. An example provided by Brown and Levinson (1987) is "Damn, I'm out of cash, I forgot to go to the bank today" (Brown & Levinson, 1987:316). The speaker's intention is not clear here; He may want to borrow some money from the hearer or is

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just plainly stating that he has run out of money. Off-record strategies contain metaphor, irony, and rhetorical questions, etc. which causes the speaker's intention to be ambiguous.

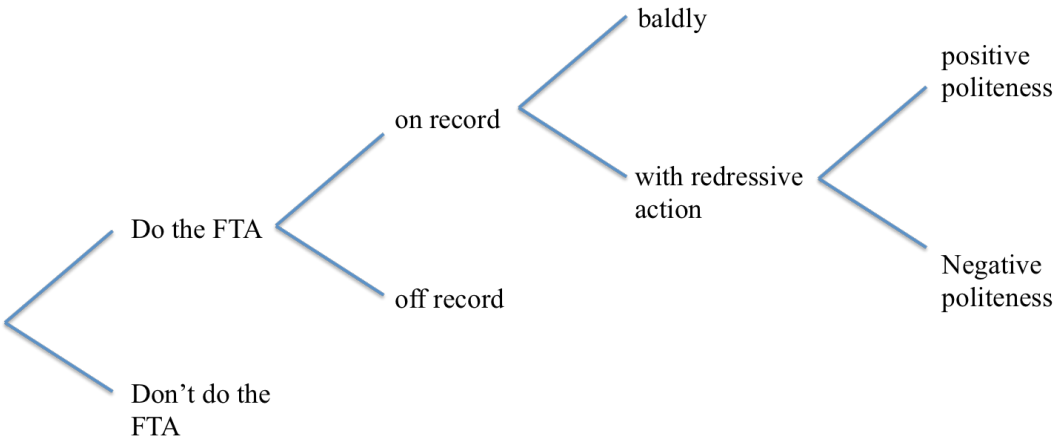

Figure 1. Possible strategies for doing FTAs

When a speaker does a communicative act baldly without redress, it is direct and unambiguous. For example, a request is bald if the speaker says, "Turn on the light!" In Brown and Levinson's (1978) analysis, an FTA done by a speaker without redress is categorized into one of the following three conditions; the first condition is that both the speaker and the hearer agree that the need to maintain face can be postponed due to urgency. The second condition is when the degree of threat to the hearer's face is very small and the speaker does not need to sacrifice much, such as "Do sit down." The final

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condition is when the speaker has great power over the hearer, or can get support from the audience to damage the hearer's face but not his own.

Brown and Levinson (1978) define actions that "give face" to the hearer as redressive actions in which an FTA is not intended or wanted. When the speaker performs a redressive action, the hearer's face is acknowledged and the speaker will try to maintain the hearer's face wants. There are two kinds of redressive actions – positive redressive action and negative redressive action. A positive redressive action focuses on the hearer's positive face, and to a certain degree, the speaker is concerned with the hearer's wants. So the speaker may treat the hearer as his friend or an in-group. An FTA is minimized because the speaker sympathizes with the hearer and tries to appeal to the hearer's positive face. On the contrary, negative redressive actions satisfy the hearer's negative face or his desire to maintain self-determination. Negative politeness strategies are applied when the speaker acknowledges and respects the hearer's negative face and avoids to impede the hearer's action.

Brown and Levinson considered the sociological variables which determine the seriousness of a face-threatening act (FTA). There are three factors: (1) the 'social distance' (D) (familiarity between S and H, a symmetric relation), (2) the relative

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‘power (P) of S and H (an asymmetric relation), and (3) the absolute ranking (R) of impositions in a particular culture (Brown and Levinson, 1978). (Brown and Levinson even propose a formula for calculating the weightiness of an FTA, using “D,” “P,” and “R” as variables. However, the weightiness is not our focus so we do not put emphasis on it.) According to their definition, the seriousness of an FTA contains both risk to a speaker’s face and risk to a hearer’s face depending on the type of the FTA. For example, requests and offers tend to threaten both parties’ faces, while apologies threaten a speaker’s face, and advice and orders typically threaten a hearer’s face. While Brown and Levinson’s politeness model is not specific for doctor-patient communication, the model can help provide an explanation for the facework between doctors and patients under politeness constraints. According to the politeness model, language is regarded as social practice and the means to negotiate. Though in Brown and Levinson’s (1978) examples, the utterances they analyzed were collected from different dialogues that were difficult to present the diversity of certain social interactions.

Though the politeness model is not specialized for doctor-patient communication, it provides the possibility to examine their communication under the politeness domain.

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In fact, during consultation, doctors would raise questions and come up with recommendations which may threaten patients' face. On the other hand, when facing doctors who have authority and power in an institutional structure, any active acts from patients could be regarded as face threats (Aronsson and Sätterlund-Larsson, 1987). During consultation, doctors sometimes raise questions that might threaten patients' faces or give recommendations with implied criticisms. Aronsson and Satterlund-Larsson (1987) investigated the dialogue between doctors, adult patients and their family. They discovered that politeness and clarity may not always be satisfied at the same time because doctors' most face-threatening acts were softened by indirectness. For instance, when a patient needs to get undressed for examination, the doctor might say, "You could perhaps undress a little and then we'll examine your thighs…" In this request, the doctor softens the request through negative politeness by being conventionally indirect, using hedges, and minimizing the level of imposition. On the other hand, the request can also be applied through positive strategies like using the plural form to imply collaboration. These strategies softened the face-threatening degree of the doctor's request but may be less clear. So in Aronsson and Satterlund-Larsson's study, after the doctor's request, some of the patients were not certain with regards to

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how much clothing they should take off or if they needed to get undressed at all.

2.3 Power

Doctor-patient relationship involves power relationship. Tannen (1987) suggests that power is always metaphoric when related to interaction and discourse. That is because there are different kinds of power and people take different roles. Between doctors and patients, power determines their asymmetrical relationship; doctors take the dominant role while patient the subordinate, which leads to an imbalanced status (Tannen, 1994). Thus, under doctor-patient relationships, doctors could exercise power to inform patients according to their medical knowledge and even persuade them to accept their advice (Burgoon et al., 1990; Ryn, 1997). According to Kettunen and Gerlander (2002), from the view of doctor-centered paternalistic, power is shown during the health care process "by using jargon, dictating the topics, disregarding the patient's initiative, interrupting, questioning, and controlling the time" (Fisher and Groce, 1990; Jarrett and Payne, 1995; Cegala, 1997; Chapple and May, 1997; Binbin, 1999; von Friederichs-Fitzwater and Gilgun, 2001). However, in interpersonal communication, power is complicated and contextualized because the same utterance could convey both

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power and solidarity at the same time, depending on the context (Tannen, 1994).

From the traditional paternalistic view, patients are regarded as the passive ones to receive information with few questions or requests. They are not actively involved in communication, and do not express the need for more information or show and clarify their confusion (DiMatteo, 1991; Binbin, 1999; Lambert et al., 1997). On the other hand, according to a study by Ainsworth-Vaughn (1995), though with different power statuses, doctors and patients use the same power strategies but in different ways. For example, doctors tend to ask direct questions while patients ask questions in a more indirect or polite way. Moreover, patients are gentle while asking questions in order not to threaten doctors' domain. Thus, their questions would contain short pauses. During consultation, patients would keep bringing up the questions or problems to continue the topic actively or propose treatment options by themselves. (Ainsworth-Vaughn, 1995). Thus, power is performed through individual action and interaction within the sequential organization, not rooted in the characteristic or role of doctor and patient. During negotiation, doctors and patients work together to build authority and power.

The medical consultations we collected are examined under the doctor and patient's asymmetry power status and different politeness strategies while they strike to

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achieve their communicative goals. In Chapter 3, the methodology of conducting the study is presented.

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Chapter 3. Methodology

In this study, the talk exchange between doctor and patient parties in 45 medical encounters in an ophthalmology clinic in National Taiwan University Hospital (NTUH) were observed and analyzed. The age of the recruited patients ranged from 45 to 85 years. There were in total 45 patients (16 male, 29 female) and 6 family companions included in our study. The family members who accompanied the patients were 2 wives, 1 husband, 2 daughters, and 1 son. The study was approved by the Institutional Review Board (IRB) of National Taiwan University Hospital (NTUH) with the number: 201612117RINB. Our study was conducted according to the rules of IRB and the participants' right was fully protected by the researcher. If the patients or their family companions were under 20 years old, they were excluded from the study because according to the rules of IRB, they are vulnerable subjects who need extra-protection if they are included in the study.

Because these patients' eye conditions were chronic (the process of the disease is over a period of time, such as cataract, glaucoma, age-related macular degeneration AMD, etc.) but not urgent in nature, most of the patients visited the ophthalmologist on a regular basis for three months, six months, to one year or so depending on the

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condition of their eyes. Therefore most of the patients and their companions in the study were well-acquainted with the doctor. Only 4 consultations were first-time visits and most of them were referred by other specialists from other hospitals. The ophthalmologist in our study is an expert in the retina-related field. The average number of patients in each clinic session is around 90. There are many patients who live outside the metropolitan areas of Taipei and would spend hours traveling just to see this doctor at the National Taiwan University Hospital. Operating hours are in the morning or in the afternoon. In the morning, the clinic begins at 9AM and ends around 2PM; in the afternoon, it begins at 1:30PM and ends around 6PM. The average time for each consultation is around 4 minutes. The Ophthalmology Department belongs to the Surgical Department and ophthalmologists can diagnose the disease directly from the patient's eyes when their pupils are dilated (unlike interns who can only diagnose from the patient's description of symptoms or conduct basic examinations, and are unable to perform any surgical treatment.)

3.1 Data Collection

In order to have a better view on the doctor-patient communication in Taiwan, the

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face-to-face consultation between doctors and patients were investigated. The patients and their families were invited to participate in this study by 1 doctor in the eye clinic prior to their consultation. The goal and method of the study were explained by the doctor. If the patient and their companion agreed to join this study, the entire consultation would be recorded and later transcribed. The patients' identities would be delinked and their identities would not be revealed. The data collected could only be used for academic purposes.

With regards to the setup of the clinic, patients were asked to sit on a chair near the doctor for the examination while an ocular slit lamp was on the other chair. Usually, there were two nurses in the clinic. One would face the table with a computer while working on patients' appointments and scheduling upcoming examinations. The other would stand next to the door to help with the flow of patients going in and out of the clinic, instructing the patients to sit on the right seats (facing the doctor or in front of the ocular slit lamp) and give them the prescription sheet.

During the consultations, as a researcher, I sat on the chair farthest from the door and behind the doctor, observing the entire sessions without interfering. When the doctor invited the patients and their families to join the study and have them sign the

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informed consent, I would start to record the consultation and later transcribe the conversation.

3.2 Theoretical Background

The data in our study is transcribed and examined qualitatively under concepts of Discourse Analysis (DA). “The main strength of the DA approach is that it promises to integrate linguistic findings about intra-sentential organization with discourse structure.” (Levinson, 1983:287). Discourse analysis is the study of language in context that develops from linguistic studies and semiotics (Potter & Wetherell, 1987; Edwards & Potter, 1992; Starks & Brown Trinidad, 2007). It focuses on language-in-use and examines how participants achieve personal, social, and political communicative goals through language (Tannen et al., 2015). From the viewpoint of discourse analysis, language and words are basically meaningless but are a system of signs and meaning that is generated through the shared and mutually agreed-on use of language (Starks & Brown Trinidad, 2007). Human beings’ understanding and perception of reality is constructed by language. In addition, language defines people’s social roles and they can establish their identities through it (Chandler, 2002). Since language is the primary

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means of our communication, discourse analysis examines how language shape and reflect cultural, social, and political activities (Crowe, 1998; Gee, 2014).

Health communication provides a chance to study the relation between discourse and healthcare. “Discourse” here is defined as “‘contextually sensitive written and spoken language produced as part of the interaction between speakers and hearers and writers and readers” (Candlin et al., 1999:321). For many linguists, language is perceived not simply a reflection of relations in social life, but it actively contribute to the construction and constitution (Kress, 1988; Fairclough, 1992; Candlin et al., 1999). In healthcare and health communication, language plays a very important role in the medical settings and discourse is the core of healthcare that reflects the communication and patient satisfaction (Harvey & Adolphs, 2012).

3.3 Analytical Framework

The purpose of our study is to understand how linguistic strategies are used by the participants in the decision-making process while saving each other’s faces during the medical encounters. The linguistics cues are then compared with the politeness model and show how the communication is negotiated and co-constructed by the participants

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in institutional context. Because medical discourse is complex and influenced by the participants' social roles, the use of politeness strategies to save the participants' faces is marked. The cases of this study contain medical discourse between two parties (doctor and patient) and three parties (doctor, patient, and companion).

First, we go through the transcription and pay attention to the decision-making process between the doctor and patients. The linguistic strategies corresponding to the distinction of Brown and Levinson's (1978) politeness model are marked. Later, we select three politeness strategies that used by the participants in both two parties and three parties communication: (1) bald recommendations, (2) collaborative plural, and (3) hedges. The three strategies are the main focuses of the analysis but because the communication is dynamic, the excerpts are studied sequentially. The context of the discourse plays a very important role in medical encounters. Though Brown and Levinson (1978) proposed clear divisions of politeness strategies, the real application of politeness by the participants in our study is influenced by specific social and cultural factors. Some more detailed analysis of the three strategies is in Chapter 4.

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3.4 Data Transcription

The dialogues between doctor, patients, and companions were tape-recorded and transcribed *in extenso*. We listened to the conversation for each consultation and checked the transcript many times to make sure the transcription can reveal the details of the verbal communication between the participants. We focus on the politeness strategies that the doctor and patient party use during the medical consultations and draw the concepts from Discourse Analysis. The transcription contains the features related to the possible politeness strategies appear in their consultations, so the speaker's emphasis, overlaps, and code-switching are marked but not other minor linguistic features. (The transcription convention is in page iv.)[1] In the transcription, the participants' names or addresses are fictionalized to protect their anonymity.

[1] [ ] Beginning and ending of overlap in speakers' utterances
? Upward intonation
CAPITALS Relatively high amplitude (in Mandarin transcription: **bold**)
/ / Encloses description of how talk is delivered
_____ Code-switching (e.g. Taiwanese)
= Latching
.. Short pause
… Long pause
[…] Text omission

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Chapter 4. Politeness Strategies in Medical Communication

This chapter presents the data and analyses of the politeness strategies used by two role combinations during the medical consultations – two parties (doctor and patients) and three parties (doctor, patient, and companion). The linguistic strategies they use may threaten or save the hearer or the speaker's faces depending on their communicative goals. Most of the studies related to medical communication only focus on two parties. When three parties are involved, the medical encounters are much more complex and difficult to analyze not only because the dialogue is more complicated but because the participants are constrained and influenced by others' social power and status. We select three politeness strategies that appear in both the consultations of two parties and three parties in their medical decision-making to see how linguistic strategies are applied when they seek to achieve their communicative goals while saving each other's faces. The results support that doctor-patient communication is a complex process that is negotiated and co-constructed by the participants while they are under power asymmetry in an institutional authority structure.

Nowadays, medical decision-making is often negotiated by both doctors and patients since the concept of patient-centered care has received wide attention. Their

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negotiation is a process of mutual persuasion. In medical consultations, doctors give recommendations and advices while patients make requests or express their preferences for medical treatments. These communicative acts are regarded as face-threatening acts in medical communication. Examples in this chapter are excerpts from the dialogues between doctor, patients, and family companions to demonstrate how the two parties and three parties save each other's faces while achieving their respective communicative goals with a power imbalance.

4.1 Strategies in Dyadic Interaction

In Brown and Levinson's (1978) politeness model, the possible strategies for performing FTAs are categorized and explained. When the speaker is performing an on-record FTA with positive politeness strategies, he tries to maintain the hearer's positive face and considers himself to be in the same group with the hearer and thus the face-threatening degree decreases. Some positive politeness strategies are: seeking agreement, avoiding disagreement, and giving reasons, etc. In addition, if the speaker includes both the hearer and himself in the activity equally, it is a positive politeness strategy. For example, the requests may contain in-group identity markers, such as "we" or "Let's do something together." On the other hand, when performing on-record FTAs

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with negative politeness, the speaker shows respect or deference to the hearer and maintains the hearer's negative face by caring about his need to be unimpeded. Some possible negative politeness strategies are: using questions or hedges, apologizing, avoiding using pronouns, etc. In our study, we focus on three particular strategies used in dyadic and triadic communication: bald recommendations, collaborative plural, and hedges. These strategies are mainly used when the doctor and patients are discussing about the diagnosis and medical treatments. The doctor provides medical advice while the patients request their preferred treatment and asks questions. Taking into account the circumstances during medical consultation, such as building rapport under limited time and the asymmetry of power and medical authority, the politeness strategies applied by the participants is able to reveal the interest of medical communication.

4.1.1 Bald Recommendations

The bald on-record strategy is most direct and unambiguous politeness strategy; for example, the demand "Wash your hands" is a bald act (Brown & Levinson, 1978). A bald act can be done when the speaker is not afraid of the hearer, the speaker has greater power over the hearer, or when their social distance is close. These conditions are also

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seen in the medical consultations.

In our study, the doctor has good communication skills and can usually create and maintain a harmonious atmosphere in the clinic. Most of the patients visit on a regular basis so to some degree they are familiar with the doctor. When the doctor gives medical advice or requests, he usually tries to maintain the patient's positive or negative face. However, there are circumstances when the doctor or patients perform an act baldly and without redress.

In Excerpt 1a, the doctor was surprised when he realized that the patient had the nutrition supplements that were not scientifically tested. Therefore, he gave the recommendation that the patient stop taking the supplements and spending money on them.

Excerpt 1a

The doctor examines the test results on the screen.

1 DOC: 還是有一點點水誒 還是有一點點水
There is still some fluid inside the retina…. There is still some fluid inside your eye.

2 PAT: 又又有水了.. 右右眼？
There is still some fluid a..again… In the right right eye?

3 DOC: 恩..
Mmm..

4 PAT: 右邊有水

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There is fluid in the right [eye]

5 DOC: 對..

Yes..

6 PAT: 嗯.. 又有水 我之前吃那個幹細胞

Mmm.. there is fluid [in my eye] again. I had stem cells.

7 DOC: 你吃幹細胞？

YOU HAD STEM CELLS?

8 PAT: 恩我吃人人家介紹的

Yes. I did. Someone recommended them.

9 DOC: 阿呀不要浪費那個錢啦

Come on! Don't waste your money on that!

10 PAT: 那個什麼胎盤 鹿胎盤

That so-called placenta, deer placenta.

11 DOC: 你絕對不要去亂吃 haa 拜託 haa

You should definitely not take any unproven remedies. Please!

12 PAT: 他說可以修復什麼

It is said that it can repair the…

13 DOC: 我絕對不相信那些 不要浪費錢

I absolutely do not believe in them at all. Don't waste your money.

14 吃了一大堆雜七雜八的東西在身體 好 看正前方

Having those things in your body [may not be good]. OK. Look at the front.

Examination

In this excerpt, we see that there was some fluid in the patient's right eye and the problem could not be solved by the medicine or the eye drops. Usually such a problem wouldn't be solved until the eye starts absorbing the fluid by itself. The absorption process might take weeks, months, or even years. The patient visits the doctor regularly every four or six months and in this particular visit the doctor told him that there was

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still some fluid in his right eye. The patient told the doctor that he had been taking stem cells (Line 6). Hearing that the patient had stem cells which were not scientifically tested, the doctor was very surprised and raised his voice in Line 7. The patient admitted and said the practice was recommended by someone else. Starting from Line 9, the doctor tried to persuade the patient not to take stem cells extracted from deer placenta. Instead of using other politeness strategies in his recommendation, the doctor gave the advice baldly to show his disproval. For instance, the doctor said "阿呀不要浪費那個錢啦 Come on! Don't waste your money on that!" (Line 9) directly to show how much he disagreed with the patient. This clear and unambiguous request that the patient was just wasting money on buying unverified supplements was a bald act that threatened the patient's face. Usually, the doctor would try to save patient's faces when he was giving recommendations so the form of his request was rarely imperative. This time, however, the doctor was really surprised and he hoped the patient could undergo proper treatments.

As discussed here, the doctor took a clear stance that he disagreed with the supplements whose medical effects were without scientific evidence. In Line 11, the doctor even used "絕對 must not" and "拜託 Please!" to keep the patient from taking the

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supplements. “拜託 Please!” in the request form is not commonly used by the doctor in medical consultation. Sometimes, when one party used “Please!” as a request for the other party, usually it is from the one with less power or between intimates. In this example, “Please!” from the doctor was similar in tone to “Please do me a favor! Don’t take those supplements which may not be good for your health!” The doctor treated his conversation partner not only as a patient but like a friend. The use of “阿呀 Come on” and “拜託 Please” shows the doctor and the patient have close social distance. And the doctor can frankly express his genuine opinions. Otherwise, the doctor could just say “Oh, if I were you I would think twice before I took stem cells.” Or “I do not consider taking stem cells good for your eyes.”

However, the patient was not convinced by the doctor and he believed that the supplements may have special curing effects. In Line 12, the patient tried to persuade the doctor that the supplements were said to have curing effects, like repairing the cells or the human body. The doctor immediately replied “我絕對不相信那些 不要浪費錢 I absolutely do not believe in them at all. Don’t waste your money.” (Line 13) The doctor strongly disagreed with the patient taking stem cells by using negation (don’t) and intensifier (at all) and repeating “don’t waste the money” one more time. (The first time

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the doctor told the patient not to waste money on the supplements is in Line 9.) Because the stem cell extracts were not the supplements on prescription and not covered by health insurance, the doctor kept saying "don't waste the money" and that he personally didn't believe in the curing effect of the stem cells extracts. The idea of not wasting the money is something beneficial to the patient. And the doctor did not want the patient to waste his money on the extracts showing that the doctor cared for the patient.

In fact, during the consultation, the doctor's recommendations were rarely bald according to the politeness model. In most cases, the doctor tried to maintain the patient's faces when giving advice or making requests. This example of bald recommendation here and the use of "阿呀 Come on" and "拜託 Please" showed the intimacy between the doctor and the patient. Only when the doctor and the patient were close enough, would their consultation contain these expressions. However, even though the doctor showed his strong disapproval of the extraction, the patient still seemed to believe in its curing effect near the end of their consultation.

Excerpt 1b

1 PAT: 沒有 那這邊要開眼藥水嗎 藥還沒用完
No. Then will [you] prescribe eye drops? There are still some left.

2 DOC: 好吧 那我看多久再幫你追蹤 半年再看好了 厚
Alright. Then I'll see when your next appointment should be. Let's meet

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half a year later. OK.

3 PAT: 好

OK.

4 DOC: 厚 半年 讓自己放輕鬆來 生活正常 不要熬夜 厚

OK. Half a year. Relax yourself. Have a regular lifestyle. Don't stay up late. OK.

5 PAT: 鹿胎盤 他說什麼可以吃 修復身體

About the deer placenta. They said that it can repair the body.

6 DOC: 我從來都不相信這些 你就能吃能睡 頂多就吃一些什麼 什麼葉黃素這樣

I never believe in those kinds of things at all. You just eat well and sleep well. Or at most try something like lutein.

7 PAT: 他說可以修復身體一下

They said I could try to repair my body.

8 DOC: 嘻嘻嘻

Hehehe /laughing/

9 PAT: 癌症都可以修復

That even cancer can be cured.

10 DOC: 世界上有這種藥的話 那就 就天下太平了 不用不用有這些醫生了厚

If such kind of medicine exists, everything will be fine and all at peace. No need to go to the doctors. Ok.

11 好 那就半年再追蹤 好不好 厚 好自己那個厚=

Alright. Then the follow-up will be in half a year. Is that ok? Ok. Ok you take care ok=

12 PAT: =半年

=half a year

13 DOC: 對 可以嗎？ 還是 還是要四個月？

Yes. Ok? Or or four months?

14 PAT: 好半年可以

Ok half a year is fine.

15 DOC: 好 半年

Ok half a year.

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In Line 4, after the doctor and the patient agreed for next follow-up, the doctor gave the advice about having a regular lifestyle. But the patient mentioned the deer placenta extract again and insisted that it can repair the body (Line 5). The doctor restated his disagreement to oppose the patient directly in Line 6. (In excerpt 1a, the doctor said "我絕對不相信那些 不要浪費錢 I absolutely do not believe in them at all. Don't waste your money.") Here, he asserted that as a doctor he didn't believe in the curing effects of the placenta extract and emphasized by "從來 never", which implied that the patient should not believe in it either. In addition, the doctor gave some advice about living a regular lifestyle. The doctor believed that the nutrition supplement that the patient could take was lutein, which is already proven scientifically to improve vision and eye health. But the patient was not convinced; besides Line 5, he mentioned in Line 7 and 9 that the stem cells extracts can repair cells and even cure those with cancer. The doctor found that the patient was not convinced due to his lack of medical knowledge and couldn't help but laugh (Line 8). However, instead of criticizing the patient directly and threatening his positive face, the doctor replied indirectly and wisely by saying "世界上有這種藥的話 那就 就天下太平了 不用不用有這些醫生了 厚 If such kind of medicine exists, everything will be fine and all at peace. No need to go

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to the doctors. Ok." (Line 9). The doctor was trying to tell the patient that there was no such miracle elixir otherwise there would be no need for doctors. If that kind of medicine really existed, people would only need to take the miracle elixir to cure all diseases, since the patient claimed that even cancer could be cured by the extract. The doctor used "厚 Ok" at the end of the sentence to seek the patient's consent to end the conversation. Without waiting for the patient's response, the doctor shifted the topic back to the follow-up appointment discussed earlier in Line 2 and 3. What is interesting here is that when the patient repeated "半年 half a year" after the doctor in Line 12, the doctor asked a yes/no question "可以嗎？Ok?" to seek for the patient's agreement and even provided an option. Usually, the follow-up is decided by the doctor because only he knew the condition of the patient's eyes and when the patient needed to come back for the next examination. Most of the patients would simply agree or mention the date which they would be available. But here the doctor provided the options of the next follow-up for either 4 or 6 months later for the patient to make the final decision. In Line 14, the patient made his choice and replied that half a year is fine. At the end, the doctor confirmed by saying "yes" by repeating "half a year".

The doctor involved the patient in the decision-making by using positive politeness

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strategies such as treating the patient as a friend, and showed that like the patient, he wanted the patient to be healthy. At the end of the consultation, the doctor respected the patient's negative face that he provided the options of next follow-up for the patient. Besides, the doctor knew the patient was nervous about his eye condition, even though his problem is stable and not getting worse. This may be the reason why after the doctor strongly opposed the stem cells extract, he asked the patient to take care of himself (Line 11)

In the next excerpt, the patient is a female with diplopia (double vision) and cataract who insisted that she needed a next appointment by making her request baldly. However, the doctor did not think that she needed a follow-up.

Excerpt 2

1	PAT:	幫我約變成你的正常正常病人 6 個月一次 6 個月一次那一種 Help me arrange follow-ups for every six months.
2	DOC:	我這邊 我就不再約了 你這 就不用看 我就幫你約給那個= As for me, I won't make an appointment [with you]. There is no such need for your case. I'll transfer you to the=
3	PAT:	=可是以前陳醫師都是每半年幫我看一次 =But Dr. Chen used to make an appointment with me every half a year.
4	NUR:	林醫師 Dr. Lin
5	DOC:	[好啦 [Fine.

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6 PAT: [對 他每次都幫我約

[Yes, he made the appointment with me every time.

7 DOC: 好啦 [你如果有必要的話 我就會幫你約啊

Alright. [If it's necessary, I'll make an appointment with you.

8 PAT: [他說 他說

[He said he said.

9 DOC: [你只是

[You're just

10 PAT: [我覺得有必要 我覺得我快要瞎了

[I think it's necessary. I think I'm going to go blind.

11 DOC: 呵呵 我覺得你沒有必要 /with laughing/

Hoho. I don't think you need it. /with laughing/

12 NUR: 呵呵呵 你的視力比很多人都好

Hohoho. Your eyesight is much better than that of many people.

13 PAT: 我覺得 我我覺得我右眼快要瞎了

I think I I think my right eye is going to go blind.

14 DOC: 不會啦

It's not.

15 PAT: 好像弱視這樣

Its vision is pretty weak.

16 DOC: **絕對不會** 你放心好了

It's ABSOLUTELY NOT. Don't worry.

17 PAT: 他都幫我每每 而且他說我的白內障有 百分之 60 了

He helped me [arrange the appointment] every every. And he said the severity of my cataract is about 60 percent.

18 DOC: 好啦 我就幫你約半年再看吧厚

Alright. I'll make an appointment with you for half a year later. Ok.

19 PAT: 那 那白內障是幾十就要開刀啊？

Then then how serious does the cataract have to be to get a surgery?

20 DOC: 視力在 0.3 0.4 以後再說 厚

When the eyesight is below 0.3, 0.4. Ok.

21 PAT: 那我現在是多少？

Then how is mine [eyesight] right now?

22 DOC: 0.5

0.5.

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23 PAT: 喔還有 0.2
Oh there is still 0.2 [to go].

First, the patient made the request baldly to ask for regular appointments. However, the doctor was a retina specialist though the patient's problem was related to diplopia (double vision). So the doctor refused the patient's request and said he would transfer the patient to another ophthalmologist whose expertise is double vision (Line 2). In their earlier discussion, the doctor already said he would transfer the patient to another eye doctor to check her double vision. But the patient did not accept it and cut the doctor off in Line 3. She claimed that her former eye doctor used to make an appointment with her every six months, and indicated that this doctor should do so, too. The patient here tried to persuade the doctor to save her positive face that The patient replied yes and again still insisted that Dr. Lin made the appointment with her every half year in Line 6. Though the doctor replied "好啦 Fine. Alright." and in Line 5 and 7, which seemed that he was persuaded, the doctor still thought it was unnecessary for the patient to make another appointment with him every 6 months. Instead, he would just transfer the patient to anther eye doctor who specializes in double vision. So the doctor mentioned the patient's problem was not serious "你只是 You're just" (Line 9), but was

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interrupted immediately by the patient again who claimed that she was going blind. According to the doctor (from Line 11 to 16), the patient will not go blind, and her case is not that serious at all. Hearing her interesting responses, both the doctor and nurse were laughing. The doctor laughed and refused in a direct manner in Line 11. Though direct, the doctor was laughing at the same time which greatly decreased the harshness of his refusal. At the same time, the nurse was also laughing and responded to the patient that her eyesight is much better compared to many people (Line 12). However, the patient was not convinced at all, and she insisted again that she would go blind soon (Line 13). In order to relieve her tension, the doctor promised twice that she would not go blind in Line 14 and 16. In Line 16, the doctor even raised his tone and emphasized "**絕對不會** It's ABSOLUTELY NOT." However, the patient did not accept it so she changed the topic back to her previous appointments and her cataract (Line 17). Finally, in Line 18 the doctor gave up negotiating with the patient and agreed to make the appointment with her half a year later. Instead of saying thank you or giving minimal response to show agreement, the patient kept asking about how serious her cataract was (Line 19). Therefore, the doctor and the patient shifted their topic to discuss about how serious the cataract has to be for conducting a surgery (from Line 20-23).

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In this excerpt, the patient first baldly made her request of the next follow-up but the doctor did not agree. Then the patient exaggerated her eye problem in order to persuade the doctor to make another appointment. Even though the doctor's responses became more direct gradually, at the end, the patient succeeded in making an appointment with the doctor. For example, in Line 7 the doctor said "If it's necessary" to Line 11 "I don't think you need it." (Line 11 contains laughing which decreases the seriousness). These statements threatened the patient's positive face because the doctor tried not to make the appointment which was what the patient wanted. (The patient's statements that she thought a follow-up was needed and she was going blind were the means to persuade the doctor to make an appointment). The doctor assured the patient that she was not going blind by the rejections that were not stressed at first (Line 14 "不會啦 It's not") but later firm and emphasized in Line 16 ("**絕對不會** It's ABSOLUTELY NOT") Near the end of the consultation, the doctor unwillingly agreed to make an appointment with the patient harmed his own negative face because this against his own will. During this consultation, the patient made many requests, raised questions, and shifted topics which actively took control of the progress of the consultation.

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4.1.2 Collaborative Plural

Using in-group identity is one of the positive politeness strategies because the speaker treats the hearer as an in-group or a friend, and the addressee's positive face is maintained. Aronsson and Sätterlund-Larsson (1987) pointed out that during medical consultation, doctors tended to use collaborative plurals ("我們 we") as a positive politeness strategy to involve both themselves and the patients in the decision-making. However, from our observation, most of the time when the doctor used collaborative plurals, it did not mean that the both of them are the subjects of the activity, only the patient or the doctor was. But using the collaborative plurals gave patients a sense that they were standing together and working as a group, which benefited the doctor-patient communication greatly. Below are excerpts containing collaborative plurals.

Excerpt 3

Examination

1 DOC: 主要還是白內障啦厚
The main problem is still cataract.

2 PAT: 嗯
Mmm.

3 DOC: 視網膜是還好啦 好 如果沒有問題我們就 半年來看就好了厚
The retina is fine. Alright. If there is no problem let's just meet in half a year. Ok.

4 PAT: 好 白內障還 還是很嚴重是吧？

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Ok. The cataract is is still serious right?

5 DOC: 你如果 還可以看得到就沒有關係厚

If you can still see then it's fine. Ok.

6 好 我們就約半年再來追蹤厚 好 好

Ok. Let's meet in half a year for the follow-up. Ok. Ok.

7 PAT: 藥還是拿相同的

The prescription is still the same.

8 DOC: 嘿 對 開一樣的藥厚 好半年再追蹤

Hey. Yes. I'll prescribe the same medicine. Ok. Our follow-up is in half a year.

9 NUR: 外面等厚 外面等一下

Wait outside. Ok. Wait outside for a while.

The doctor used collaborative plurals to include both him and the patient into the decision-making which is a way to maintain the patient's positive face (in Line 3 and 6). The use of "我們 we" implied that both the doctor and the patient work as a group to make the decision together (though the time for next follow-up was totally decided by the doctor). The collaborative plurals here referred to the doctor and the patient. To some extend, both doctor and patient needed to appear in the next follow-up and their interaction needed their cooperation. The use of collaborative plurals here somehow reflected how we perceived the interaction.

Interestingly, because the patient visited the doctor regularly and he was familiar with the procedure of the consultation and his previous medical treatments, he mentioned the prescription first which is usually proposed by the doctor during medical

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consultation. The doctor confirmed that he would prescribe the same medicine and reminded once again that the follow-up would be in half a year (Line 8).

Excerpt 4

Examination

1	DOC:	看正前方... 看天花板... 看左邊.. 上方一點點… 看右邊… Look at the front… look at the ceiling… look to the left… a little bit higher… look to the right.
2		好 很好厚 看起來都 OK 了 好 Ok. Good. OK. Everything looks fine. OK.
3		不舒服的話我們還是可以開一份藥水厚 不舒服點一下 厚 If your eyes don't feel well we can still prescribe eye drops. OK. Apply them when [your eyes] feel uncomfortable. Alright.
4		那視網膜都 OK 就平常還是不要過度使用眼睛喔 厚 The retina is OK. Just don't overuse yours eyes. Alright.
5		還是半年來 追蹤就好了 厚 好 沒問題 厚 嘿 Just come back in half a year for a check-up. Ok. Alright. No problem. Okay.
6	PAT:	好 謝謝 OK. Thank you.
7	DOC:	下次來測個視力 散瞳 好 沒問題 Next time you will have a vision test, pupil dilated. OK. No problem.

In the excerpt above, the doctor used collaborative plurals when he prescribed the medication. In Line 3, the doctor said "不舒服的話我們還是可以開一份藥水厚 If your eyes don't feel well we can still prescribe eye drops. OK." However, only the doctor can make prescriptions, so the subject should be "I" instead of "we" here. The

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statement should be, “If your eyes don’t feel well, I can prescribe eye drops for you. The usage of collaborative plurals from the doctor may make the patient feel that he was involved in prescribing the eye drops together with the doctor. The doctor used first personal plural to include the patient in the action, which was a positive politeness strategy because the doctor treated the patient as an in-group and to satisfy the patient’s need.

Excerpt 5

1	DOC:	我們去做個檢查 好不好？
		Let’s do an examination, ok?
2	PAT:	好好 好好
		OK. OK.
3	DOC:	白內障看起來是沒問題啦 會不會是黃斑部的問題
		The cataract looks fine. Or maybe the problem has to do with macula?
4	PAT:	對那個有個醫生 我們那邊那個王 OO 醫師
		Yes, there’s this doctor in our neighborhood, Dr. Wang.
5		他是說 跟我說是黃斑部的問題 病變
		He said [he] told me it’s related to macula, degeneration.
6	DOC:	沒關係我們帶你去做個檢查回來就知道了厚
		It’s ok. Let’s do a test and we’ll know the results.
7	PAT:	好
		OK.

The in-group identity markers that appeared in doctor’s request illustrate one of the positive politeness strategies. In Line 1 and 6, the doctor used “我們 we” twice when

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he asked the patient to undergo some examinations. The first “我們 we” on the surface indicated the doctor and patient. However, only the patient needed to undergo the examinations. At the end of Line 1, the doctor used a tag question to seek the patient’s agreement. (And the patient immediately agreed in Line 2.) In fact, using a question with request is a negative politeness strategy because the patient’s action was constrained by the doctor’s request. Therefore, Line 1 contained positive and negative politeness strategies at the same time. The second “我們 we” in Line 6 referred to the staff, which were the nurse and the doctor. But there was only the nurse who would take the patient to the exam room. In short, when the doctor used the collaborative plurals, the patient may feel that they are in the same group and become more willing to follow the doctor’s instructions.

4.1.3 Hedges

In Brown and Levsinson’s (1978) politeness strategies, a hedge is defined as “a particle, word, or phrase that modifies the degree of membership of a predicate or noun phrase in a set” (Brown & Levsinson, 1978:145). In their argument, daily communication poses a threat to cooperative interaction. Any presupposed request or

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promise can potentially threaten the hearer or the speaker's face. When a hedge is used in the FTAs, it avoids commitment to the presupposition, and it can be regarded as a primary and basic method to decrease potential threats in interaction. In the medical context, hedges are mostly used to soften the statement in order to decrease the face-threatening degree.

Excerpt 6

1	DOC:	好看下面來 很好啦厚 你現在主要是
		OK look down. It's good. Your main [problem] is
1		[誒
		Ai
3	PAT:	[不過我看東西都霧霧的耶 不是像這眼開的那樣那麼清楚
		But now everything I see is blurry. It's not as clear as the eye with surgery.
4	DOC:	你現在這一眼可以去點明了 我已經幫你開 點明了
		Now this eye can undergo surgery. I already conducted the surgery for you.
5	PAT:	點名了
		Already conducted.
6	DOC:	阿這一隻眼 0.7 厚 還可以啦還可以啦 這 我想 暫時厚=
		And this eye's vision is 20/30. Okay. It' alright. It's alright. I think for the time being that=
7	PAT:	嗯
		Mmm
8	DOC:	=沒必要去開刀了因為開刀=
		=there's no need for surgery because=
9	PAT:	厚
		Okay.
10	DOC:	=也是有開刀的風險在
		=there's still some risk involved.

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11 PAT: 他這個是怎麼樣？
What's wrong with this?
12 DOC: 眼睛裡面多長 長了一層膜仔
There's an extra membrane in the eye.
13 PAT: 厚喔
Oh oh.
14 DOC: 這個很多人都有啦 厚=
Many people have this. Alright=
15 PAT: 嗯
Mmm
16 DOC: =有的人比較厚 有的人比較薄 厚
=For some it's thicker, and for some thinner. Okay.
17 PAT: 阿 阿有 有什麼能夠改善的？ 沒辦法？
Can can anything be done? No?
18 DOC: 這 就跟 你的頭髮會變白一樣 這都是老化引起的
It's just like your hair turning gray. It's caused by aging.
19 PAT: 厚 厚
Ok ok.
20 DOC: 不得已再來開刀了啦厚
Surgery should be the last resort. Ok.
21 PAT: 好 [好好
Ok. [Ok ok.
22 DOC: 但是[你現在視力還不錯 厚
But right now [your vision is not bad. Okay.
23 PAT: 好好
Ok ok.

In Line 3, the patient did not wait for the doctor to finish his description of her symptoms but cut in. She said that the vision of the eye on which the surgery had not been performed is blurry, compared with the one where the surgery had already been done. However, the doctor knew the patient did not need the surgery yet so he started to

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convince the patient. In Lines 6 and 8, the doctor said her vision is 20/30, which was still okay, so there was no need to undergo the surgery right now. The doctor used the hedge "我想 I think" to turn his statement into a request that right now a surgery was no need for the patient yet. The doctor's request somehow threatened the patient's negative face because she thought her vision was blurry and she believed that underwent a surgery would help but the doctor did not approve. The doctor used the hedge to help decrease the face-threatening degree. He tried to persuade the patient that the surgery was not the best solution for her right now and even mentioned there were risks of any surgery in Line 10 to further build up his persuasion. The patient did not accept the doctor's advice right away but asked about the condition of her eye problem (Line 11). (If the patient had accepted the advice at least she would have given a minimal response, such as "uhm" or "ok"). Therefore, the doctor went on to explain that her problem was caused by a new membrane growing in the eye (Line 12), which however was quite common because many people had membrane growth, too (Line 14). The doctor kept comforting the patient by explaining that the thickness of the membrane depended from person to person (Line 16). In Line 14 and 16 the doctor tried to convey that her situation was not rare but a common problem. However, the patient was not

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satisfied so she asked about other solutions to the problem, since the doctor did not suggest surgery as a solution in Line 17 "阿 阿有 有什麼能夠改善的？ 沒辦法？ Can can anything be done? No?" The patient first asked an open-ended question directly to see if there was any solution, but followed with another question to show that she was pessimistic about it. Tactfully, the doctor did not answer that there was no better way to treat the problem but explained the cause of it was due to aging, just like when hair turns gray (Line 18), and that if it became serious then surgery would be the last resort (Line 20). So this explanation allowed the patient to know that only when her vision got worse that she should get the surgery. Starting from Line 19, the patient seemed to be persuaded by the doctor so she started to give some minimal responses "厚 厚 Ok ok.." and "好 好好 Ok. Ok ok."

Sometimes the doctor would not answer the patient's question directly but chose to explain the reasons or analyze the pros and cons of the medical treatment while not being too direct in order to save the patient's face. In the end, the patient would understand the condition and accept the doctor's suggestion.

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4.2 Strategies in Triadic Interaction

Doctor-patient-companion communication is more complex than doctor-patient communication in medical encounters. Companions (e.g. spouses, family members, friends) usually accompany the patients to medical consultations and provide emotional support and involve in the medical treatment decision-making (Clayman et al., 2005; Wolff and Roter, 2008). The presence of a companion can influence the dynamics of the consultation, change the doctor-patient communication, and increase the complexity of the consultation (Beisecker and Moore, 1994). Previous researches show that companions in medical consultations are mostly family members and females (Greene et al., 1994; Baker et al., 1997; Ishikawa et al., 2005; Laidsaar-Powell et al., 2013).

In Taiwan, it is common for the elder patient to have companions when visiting the doctor. The companion can be their spouse or children (though the children may not live with the elderly). In medical consultations, the patient will describe their symptoms or request some treatments or raise questions. If their family is also in the clinic, sometimes they will speak up for the patients to make some requests or ask various

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questions about the patient's illness. In this section, the politeness strategies used in the triadic communication will be addressed and analyzed.

4.2.1 Bald Recommendations

When an act is clear and unambiguous, it is categorized in the on record bald act without redress. The bald recommendations are used when the speaker is more powerful or when their social distance is so close that the need to maintain the hearer's face is minimized. The power imbalance among the participants in the medical encounters can be demonstrated with bald recommendations.

In the example below, the patient with glaucoma came to the clinic with his daughter. The patient lived in Hualien, the eastern part of Taiwan and he already saw the doctors in Hualien. It takes about two and half hours by train from Hualien to Taipei. After the patient and his daughter entered the clinic, it was the daughter who took the active role to communicate with the doctor.

Excerpt 7

Examination

1 DOC: 還好啦

It's okay.

2 DAU: 他說會有一層薄膜…

He said he feels a film over his eyes …

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3 DOC: 他的視神經不大好耶

His optic nerves aren't that good.

4 DAU: 對啊 所以 所以變青光眼

Yeah so so it led to glaucoma.

5 DOC: 他有青光眼喔是不是？

So he has glaucoma?

6 DAU: 對啊現在那邊 花蓮那邊醫生說他現在是青光眼

Yes, the doctor in Hualien said he has glaucoma.

7 DOC: 他住住花蓮喔？

He lives in Hualien?

8 DAU: **對啊**

YUP

9 DOC: 對呀所以他現在是青光眼喔[啊他有沒有有沒有在治療？

Ah, so he has glaucoma. Is he receiving any treatment?

10 DAU: [那怎麼辦？

Then what to do?

11 DAU: 沒有啊 只有點藥水啊

No, just using eye drops.

12 DOC: 對啊 藥水就是治療啊

Yeah. they are used for treatment.

13 DAU: 就是點那個什麼 降眼壓的那個喔？

Those that help to lower the intraocular pressure right?

14 DOC: 嗯 那個是那個哦

Yes, that's…

15 DAU: 啊 啊有沒有什麼其他的方法？

Uh uh is there any other method?

16 DOC: 就乖乖點藥水啊

Just apply them…

17 DAU: 蛤啊

Haaa

After the doctor finished the examination of the patient's eyes, the patient's daughter first took part in the consultation to interact with the doctor. So from Line 1 to

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17, there was only the daughter who spoke up in the clinic with the doctor while the patient said nothing. After the examination, the daughter said "他說會有一層薄膜… He said it feels like a film in the front…" to show that his father once said he felt like there was a membrane in the eye, causing blurry vision (Line 2). However, the patient did not describe the symptoms by himself even though he was the person who knew how blurry his vision actually was. The daughter mentioned that her father had glaucoma (Line 5) and that one doctor in Hualien confirmed that, too (Line 6). When the doctor knew the situation, he would like to know if the patient was under any treatment (Line 9). And the daughter answered, "No, just the eye drops." (Line 11) Interestingly, the doctor replied "Yes. The eye drops are the treatment." Apparently, the daughter did not understand the treatment of glaucoma. Using the eye drop is common in dealing with glaucoma and is in some cases the only way. Responding to the doctor's reply, she asked him whether the purpose of the eye drops was to decrease the eye pressure in Line 13. The daughter would like to see if there were other treatments so she asked the doctor directly "Uh uh is there any other ways?" (Line 15). This request threatened the doctor's negative face because the doctor already mentioned the eye drops are used for treatment in Line 12. The patient's daughter did not appreciate the

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doctor's answer but wanted the doctor to provide other solutions. The doctor suggested the treatment baldly that the patient just need to apply the eye drops regularly (Line 16). However, though the doctor was regarded as the most powerful one in the consultation and gave the bald and unambiguous suggest, the daughter did not accept this suggestion with the response "蛤啊 Haaa" with dissatisfaction. The daughter's response did not care for the doctor's positive face that the doctor wanted his advice be accepted and appreciated.

The patient had a headache and the doctor recommended that he needed to consult a physician for his headache. The patient's daughter tried to take the lead to control the flow of the consultation. She repeated the doctor's bald recommendation to persuade her father to visit the physician.

Excerpt 8

1	DOC:	所以你要去看 看 內科醫生啦厚
		So you need to make an appointment with the physician. Okay.
2	DAU:	你還要再看內科啊神經內科 對不對？
		You still need to see the physician, the neurologist, right?
3	DOC:	嗯
		Mmm.
4	DAU:	你還要再去看神經內科
		You still need to see the neurologist.

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5 DOC: 嘿

Yes.

6 DAU: 你還要再去掛一個神經內科

You still need to make an appointment with the neurologist.

7 PAT: 假設那個我是有去 我就還有吃那個什麼 栓 栓 那個 [血管栓塞

In case I'm going… I was taking that thr thr that [anti-thrombotic

8 DAU: [栓塞

[Thrombotic

9 PAT: 那那個預防的藥啦 啊 還有 那個 我檢查的時候 是那個

that that preventive medicine. Ah, and when I got my blood tested, it

10 三三酸甘油脂厚 還有膽固醇比較高啦那個現在 現在

showed high TG and cholesterol. And now

11 還有吃那個那個＝

I also take that that

12 DAU: ＝啊所以沒有辦法 就是點藥水 乖乖點藥水

=so there's no other way. Just apply the eye drops....apply them.

13 DOC: 對啊

Yeah.

14 DAU: 啊點藥水 然後這樣子

Apply them and that's it.

15 DOC: 這樣就好啦

That's it.

16 DAU: 這樣就好了可以控制就對了

So that's it to control it, right?

17 DOC: 是啊

Yes.

18 DAU 不會惡化 不要讓它惡化就好了

So it won't get worse. As long as it doesn't get worse.

19 DOC: 對啊

Yes.

20 DAU: 只能這樣子

Guess that's it...

Because the patient had a headache, the doctor suggested him to visit the physician

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to find out the real cause of the headache by giving the suggestion baldly in a clear and direct way (Line 1). The daughter thought her father needed to visit a neurologist, so she immediately told her father to make an appointment with a neurologist (Line 2). And at the end of Line 2, the daughter used a tag question to seek the doctor's agreement. In Line 2, the target was different because there was a code-switching. First, the target was the patient (The daughter spoke in Taiwanese with the transcription underlined). The second target was the doctor (The part in Mandarin without underlined in transcription). After the doctor only mentioned physician in Line 1, the daughter clearly pointed out it was neurologist that her father should visit. The daughter wanted to get the approval from the doctor that what she just recommended was correct. So in Line 3, the doctor gave a minimal response "嗯 Mmm." And after the daughter got the approval from the doctor, she repeated the statement baldly in an affirmative. But here only the doctor gave the minimal response in Line 5, so the daughter repeated once more "你還要再去掛一個神經內科 You still need to see the neurologist" (Line 6). The daughter repeated the bald recommendation through the doctor's authority and approval to persuade her father.

From Line 7-11, the patient started to explain that he was taking the

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anti-thrombotic medicine and his TG and cholesterol were elevated. The patient had not finished his explanation yet in Line 11, his daughter interrupted and switched the focus back to the medical treatment of her father's glaucoma (Line 12). Interestingly, this interruption was made by his daughter but not the doctor, who was regarded as the most powerful person in the consultation. This interruption showed that the daughter was active in taking the control of this consultation. After the focus switched back to treatment. The daughter was not satisfied about only the eye drops as the treatment. So Line 12, Line 14, 16, 18, and 20 were the daughter's statement about the eye drops. The doctor only gave the minimal responses like "對啊 Yeah, 這樣就好啦 That's it, 是啊 Yes" (Line 13, 15, 17, 19).

In this excerpt, though only with 20 Lines, the daughter played an important role in the excerpt. She first repeated the bald recommended that her father should see the neurologist and seek the doctor's agreement and then later when her father was talking about his condition she interrupted. At the end, she discussed the treatment with the doctor and made most the statements by herself.

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4.2.2 Collaborative Plural

The use of collaborative plural "我們 we" is a positive politeness strategy to include both the speaker and hearer in the activity. Collaborative plurals can give the hearer an idea that the participants work together in the communication and people's positive face that the want to be desirable and close to others is cared. Collaborative plural can refer to different subjects but the real indicator is different from its literal meaning.

In the except below, the consultation was about to end but the patient's wife made some requests for a closer check-up and a cataract surgery. She used collaborative plurals in her requests which referred to her husband and herself and may also arise the doctor's cooperative assumptions. In fact, the target of the check-up and the surgery should be the patient only.

Excerpt 9

1 DOC: 兩個禮拜再給我看 厚
Come back in two weeks, ok?

2 PAT: 兩個禮拜 好
Two weeks. OK.

3 WIF: 陳醫師 我尪說 請陳醫師說=
Dr. Chen, my husband said could Dr. Chen [you] please=

4 PAT: 嘿 /laughing embarrassedly/
Hey.

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5 WIF: =這邊也同樣感覺好像有點 白內障

=This eye seems to have cataract

6 PAT: 嘿 左眼這邊咁可以開 嘿嘿 /laughing/

Yes, can [I] get surgery on my left eye? Heyhey. /laughing/

7 WIF: 請陳醫師給我們再看一下 我=

Could Dr. Chen [you] please take a little look one more time? I=

8 DOC: =有啊我剛剛有看了可以開啊 這眼也是可以開了

=Yes, I just checked and getting surgery is fine. This eye is ok for surgery, too.

9 WIF: 啊你給我們安排一下 是不是請陳醫師給我們安排一下

Ah, arrange it for us. Can Dr. Chen [you] please arrange it for us?

10 DOC: 明年一月初七來開刀

Let's do the surgery next January, on the 7th.

11 WIF: [嘿

OK.

12 PAT: [明年厚

Next year.

13 DOC: 嗯 好

Mmm OK.

14 PAT: 好

OK.

15 WIF: 不然就說常常很甘苦看不到

Otherwise [he] often says it's hard to see clearly.

16 DOC: 好好 不然給你先排下去好了 /talking to the nurse/

OK. OK. How about I arrange it for you first. /talking to the nurse/

17 DOC: 好

OK.

18 WIF: 陳醫師要給你排了

Dr. Chen is arranging for you.

19 PAT: 嗯

Mmm.

Prescribe

20 DOC: 好 這樣 有給你先排下去了 厚

OK. So, it's been arranged for you already. OK?

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21 WIF: [好
OK
22 PAT: [好
OK.

Usually, the consultation would end in Line 2. But the wife started to mention the patient's other eye also had cataract. Not only the collaborative plurals, the wife applied many other politeness strategies during her request. In Line 3, the wife said "my husband said" and "could Dr. Chen please" which showed she was trying to speak up for her husband and her husband had the request for the doctor. She used "please" to seek the doctor's support to care for their positive face, to want their wants. Hearing this, the patient was a little embarrassed so he laughed embarrassingly in Line 4. The wife mentioned "cataract" with hedges like "seems" and "a little bit" which belongs to the negative politeness strategy to lessen the face-threatening degree. Instead of being direct to say that the patient wanted to have surgery for the other eye, the wife first mentioned the cataract. Here in Line 6, the patient spoke up for himself and mentioned the surgery but in a question "左眼這邊咁可以開 can [I] have the surgery on the left eye?" This request is also a negative politeness strategy that the speaker expresses the want to be unimpeded to an act. The wife used "please" and "a little" again in Line 7 to ask the doctor to check the patient's eye again. When the doctor replied that he just checked

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and he thought the other eye can have the surgery (Line 8), the wife made the request of arranging the cataract surgery first followed by a question. Both requests used hedges to soften the degree of the FTA (Line 9). Here in Line 9, the wife asked the doctor to arrange the cataract surgery for them ("us" in the discourse), which is the collaborative plural of positive politeness strategy. However, it was the patient who needed to undergo the cataract surgery but not the patient and his wife. Because the patient is suitable for the surgery, so the doctor agreed quickly in Line 10 and decided the date of the surgery (Line 10). Both the patient and wife agreed for the date in Line 11 and 14. The wife provided the reason of the surgery request in Line 15. It was because her husband can hardly see with that eye. At the end, the doctor made sure that the surgery date was reserved (Line 16 and 20) and both patient and his wife were satisfied.

4.2.3 Hedges

Ordinary communication contains potential threats to people's cooperative interaction (Brown & Levinson, 1978). Using hedges can avoid commitment to the presumptions like people's promise or request. In Brown and Levinson's (1978) definition, hedges can be regarded as the most important linguistic cues to satisfy the speaker's want. In

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addition, the underlying concept is that “don’t assume the addressee is willing to do something” and “the want to make minimal assumptions about the hearer’s wants” (Brown & Levinson, 1978:146). In our study, the participants used hedges mostly to weaken the hearer’s face-threatening degree while they were making requests or raising questions.

Excerpt 10

1	PAT:	他這次 這次這麼 效率這麼好啊 說不產 就就不產了
		They’re so “efficient”. Stopping production just like that.
2	DOC:	對 不符合成本
		Yeah, because they’re not profitable.
3	WIF:	[那個是
		That’s
4	PAT:	[哈哈哈 馬上就不產了
		Hahaha. Stopping production so fast.
5	WIF:	那個是打了也 那個是滴了也沒有用 是不是
		It is because they’re not effective? Right?
6	DOC:	有人說有用啊
		Well, some say they are.
7	WIF:	因為我先生說是有用啦
		Well, my husband did say they work…
8	DOC:	嘿
		Yup.
9	WIF:	點了以後稍微[好一點
		He got better after applying those drops.
10	DOC:	[好給我看一厚 右眼 我看看 12 月幾號
		OK. Let me see… right eye. Let’s see, which day in

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December…

11 WIF: 這一定要 治療好才有辦法 那個白內障
This must be cured so that the cataract

12 DOC: 你 如果不治療好 你開了白內障 他那個水腫就會增 更嚴重 厚
If it's not cured, even after getting the cataract surgery, the swelling will get worse. Ok?

13 所以一般是 都先把他治療到一定的程度再說 厚 好
So usually, it must be treated to a certain degree first and then we can see.. alright, ok.

The patient asked the doctor to prescribe some eye drops for curing cataract. However, the production of the eye drops stopped. In line 5, the patient's wife asked the doctor about whether there was no effect of the eye drops with a hedge, here a tag question at the end. The question about the effect of the eye drops to some extend threatened the doctor's negative face that the want to be respected and unimpeded was challenged. The doctor responded that some people said that the eye drops were effective but not saying that he thought the drops were effective may lessen the face-threatening degree in his response. The wife's assumption in Line 5 was that the eye drops were not that effective but later in Line 7 she said her husband said the drops worked. Her stance changed might because she heard that someone also said the drops were effective then she wanted to save their positive face that the effect of the drops on her husband was the same with the others. Near the end of their consultation, the doctor used the hedge "厚 Ok" twice as the finalizing note that can be regarded as the

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concession to soften the command that the swelling must be cured first but not the cataract. And the patient and his wife were persuaded and then thanked the doctor to close the consultation with satisfaction.

Excerpt 11

1 DOC: 這普通都年紀大引起的啦
This is normally caused by old age.

2 PAT: Hiou
Hiou.

3 DOC: 眼睛退化厚
Degeneration.

4 PAT: 啊現在這要怎麼弄
So what to do now?

5 DOC: 這沒有什麼特效藥捏 這要 可能要回家去吃那個 葉黃素
Well…there's no special medicine you can take... Maybe you can take some Lutein.

6 PAT: 葉黃素你寫個條子給我好不好 我再去買 不然我記了就忘記吃 什麼藥你跟我報一下
Can you write "Lutein" for me? I'll buy it. Otherwise I'll forget. Please write it for me then.

7 DOC: 不用吃你就回去保養厚 這是
You don't have to take it. Just take good care…

8 PAT: 這沒有 這沒有
There's no… there's no

9 HUS: 陳醫師可以給我們寫個明細 寫個明細 她的病歷的明細
Dr. Chen, can you help us write the details, write the details of her medical record.

10 DOC: 好好好 好好好
Ok ok ok Ok ok ok.

In Line 6, when the patient asked the doctor to write down the name of the

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supplement, she used a hedge "一下 then" at the end to soften her request. This hedge could to some degree save the doctor's negative face because the patient made a request based on the assumption that the doctor may not be willing to do so. However, the doctor was kind so when the patient's husband asked the doctor to also write down some details of the patient's health condition (Line 9), the doctor agreed. (The patient and her husband wanted to bring the note home to show their daughter what the doctor said). The husband did not use hedges in his request but use collaborative plural "我們 we" to invite the doctor to care for their wants which belonged to their positive face. The husband repeated his wife's health record many times. The doctor might be influenced by him so the agreement in his response were repeated as well.

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Chapter 5. Discussion and Conclusion

5.1 Politeness in Medical Discourse

In Brown and Levinson's (B&L) (1978) politeness model, the possible strategies for doing face-threatening acts are clearly divided. Brown and Levinson are the first to propose the clear divisions of different politeness strategies (though there might be overlaps in some categorizations) and they also take social distance, relative power, and ranking in the culture as the factors that could determine or influence participants' politeness strategies. In the excerpts demonstrated above, those different politeness strategies show how doctor, patient, and family companion negotiate with each other while saving each other's faces when under power asymmetry. In fact, B&L's model discuses the simple conversations in different cultures and societies, but not specified for doctor-patient communication. The politeness they proposed are universal but when in the medical context in Taiwan, politeness becomes very complex and interesting. In medical discourse, both doctor and patient negotiate step by step through their turn-takings and choices of different moves to create their relationships. Thought the participants have an imbalance in power, it is not just the determinant of the choice of

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the participants' face saving acts as assumed in B&L's model, but can be affected dynamically by the language the participants use. (And of course, in the situation when the doctor has good communicative skills and cares about the patients who would not try to control the consultation but would listen to the patients and care for their medical and mental needs). That is to say, the politeness strategies in medical context are much more complicated and may have different explanations from B&L's model.

From the excerpts above, we particularly discuss three politeness strategies in the dyadic and triadic medical encounters: bald recommendations, collaborative plural, and hedges. Bald recommendations appear when the speaker has vast power over the hearer. However, in our cases of medical discourse, not only the doctor, but also the patient and the patient's companion use bald recommendations in their requests and demands. The patient made the request clearly and unambiguously may because she did not afraid of the doctor's authority. The family companion gave the suggestion baldly to her father while seeking the doctor's agreement because she tended to actively control the consultation and can be viewed as the more powerful participant than the patient. Second, one of the positive politeness strategies is collaborative plural that includes participants in the activity. When collaborative plural was used by the doctor, it can

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refer to both the doctor and the patient, or the doctor and the nurse. Though the real indicator of the subject might be only the patient or the doctor. In the triadic interaction, when the family companion used collaborative plural which indicate the patient and the companion herself, she tried to ask for the doctor to maintain their positive faces. The third strategies is the use of hedges to modify the face-threatening acts. The use of hedges cares for the hearer's negative face because the basic assumption is that he may not be willing to do something. When the doctor was giving the advice, hedges can somehow soften the face-threatening degree. For the family companion, the hedges are used to soften the requests that ask for the answer or other treatments from the doctor.

If we follow B&L's model, many face-threatening acts from the excerpts are very complicated because we need to understand what are the speaker's communicative intentions and how the utterances are understood by the listener at the same time. In addition, the politeness in medical discourse is constrained by the power asymmetry between the participants and the institutional authority. Not to mention if their social distance is also a factor to influence their communication. Especially when in Taiwanese society and culture, politeness in our medical encounters is specific and

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unique. Brown and Levinson's (1978) politeness has some other explanations and applications.

5.2 Significance of the Study

Though the scale of this study was not huge, but it surely was the first one to investigate the actual doctor-patient discourse by using the politeness model in Taiwan. This study provided a chance to take a glance of face-to-face doctor-patient communication. Even though the participants themselves may not be aware of the politeness strategies they subconsciously applied, the parties did involve in the process of negotiation and created their unique dynamic social distance to achieve their goals in the communication.

From the excerpts above, the doctor, patient and companion's uses of different politeness strategies during their negotiation are influenced by their power asymmetry. Even the doctor is regarded as the more powerful one in the medical consultations; sometimes the patient uses bald recommendations to express their requests and preferences. The family companion cuts in to take control of the consultation or uses some politeness strategies with their requests. The participants adjust their

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communicative styles according to their power status, and the change of their persuasive strategies can create the new balance of power. In addition, the triadic communication is more complex than the dyadic communication in medical discourse. The presence of the third party in the medical consultation really influences the original power asymmetry and between the doctor and the patients. When the family companion is more active, there are usually more discussions in their communication.

The doctor-patient communication is a process of negotiation and co-construction by the participants. This study shows that the politeness in medical communication is influenced by the social and cultural factors in Taiwan. All the participants somehow care for the addressee's positive or negative faces and at the same time try to maintain their own faces if possible. The findings from the study illustrate how the power asymmetry between doctor, patients, and companions affect the way they use politeness strategies to achieve their communicative goals. And it also allows us to understand the importance of doctor-patient negotiation to create more equal and harmonious doctor-patient relationships in Taiwan.

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5.3 Limitations and Suggestions for Future Studies

Though the study provided some new insights related to doctor-patient communication in Taiwan, one of the limitations was that the study was conducted in only one clinic. There was only one doctor in this study, so some responses may be influenced by the personal talking style. The cases were collected in an ophthalmology department, so usually the diagnosis was clear from the examination conducted by the doctor in the clinic on the spot. Unlike the medical consultations in internal medicine, which may contain more discussions by doctor and patient about medical treatments or shared-decision making, these cases were usually simpler. Nevertheless, this eye doctor has about 100 patients in each clinic section and barely receives complaints from his patients. Also, the medical center chosen in this study was representative in Taiwan. As a suggestion, more doctors could be invited to participate in future studies. Both male and female doctors could be included as well. The consultations could be collected in other departments where the chemistry between doctors, patients, and companions might be different. In our study, there were 45 patients but only 5 family companions. This imbalance was due to the difficulty of including the participants. Otherwise, the triadic medical communication could reveal more interpersonal relationships and power

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asymmetry between the participants. Some comparison between dyadic and triadic medical communication can be done in the future studies.

Another limitation was that we particularly focused on three politeness strategies used by the participants in the medical consultation. However, their power asymmetry may be revealed by other linguistic features, such as pauses, interruptions, or questions which were not covered in our study. Future studies could focus on the features and the participants' power asymmetry may be revealed from different aspects through language. In our study, we only focused on the verbal communication in the medical consultations; however, the nonverbal communication played an important role as well. The nonverbal communication could be further explored in future studies.

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