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A PRAGMATIC APPROACH TO DOCTOR-PATIENT COMMUNICATION: A CONTRASTIVE VIEW

Theoretical introduction

1. The scope of pragmatics

Modern usage of the term pragmatics can be attributed to the philosopher Charles Morris (1938), who outlined the general shape of a science of signs, or semiotics. Within semiotics, Morris distinguished three distinct branches of inquiry: syntax, the study of *the formal relations of signs to one another*; semantics, the study of *the relations of signs to the objects to which the signs are applicable*; and pragmatics, the study of *the relations of signs to interpreters* (1938:6). Then, in the late 1960's, an implicit version of Carnap's definition of pragmatics (cf. Carnap (1959:13)) as investigations requiring reference to the users of a language was adopted within linguistics, and specifically within the movement known as generative semantics. This definition, however, was amended by Levinson (1983:5) who suggested that pragmatics refers to: *those linguistic investigations that make necessary reference to aspects of the context*, where the term *context* is understood to cover the identities of participants, the temporal and spatial parameters of the speech event, and the knowledge and intentions of the participants in that speech event.

To summarise, pragmatics is the study of language usage in context. This study, however, focuses on one particular type of pragmatics, i.e. Gricean pragmatics – not only because some other definitions of pragmatics cover much of the same ground as discourse analysis, but because this theory has become *the hub of pragmatics research* (cf. Fasold (1990:128)). Generally, the Gricean approach to discourse is basically a functionalist approach to language: explanations for language structure are sought in a general Co-operative Principle that rests upon human rationality. According to Schiffrin (1994:353): *both the constituents of discourse structure and their arrangement as coherent*

text arise because of the impact of communicative principles on the linguistic realisation of speaker meaning at different points in time. Similarly, the context proposed by Gricean pragmatics is viewed as a general Co-operative Principle that participants assume one another to believe and observe (cf. Schiffrin (1994:367)).

2. A note on Grice's theory of conversation

The term *Grice's theory of conversation* is used here to refer to a framework of utterance interpretation which was proposed by Grice in his William James lectures delivered at Harvard in 1967 and until now only partially published (cf. Grice (1975)). Levinson (1983) emphasises that Grice's theory is essentially a theory about how people use language. It attempts to show how the hearer (H) decodes the message of the speaker's (S) utterance.

Grice (1975) suggests that communication is co-operative. This means that the participants engaged in talk exchanges do not produce sets of disconnected remarks, but sets of utterances that share a common purpose or at least an accepted direction. On the basis of these assumptions he proposes the following Co-operative Principle which guides the conduct of conversation: (1) The Co-operative Principle (CP) (make your conversational contribution such as is required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which you are engaged).

This superordinate principle comprises the following subordinate rules or 'maxims': (2) The Maxim of Quantity (make your contribution as informative as is required for the current purpose of the exchange and do not make your contribution more informative than is required), (3) The Maxim of Quality (try to make your contribution one that is true, do not say what you believe to be false and do not say that for which you lack adequate evidence), (4) The Maxim of Relation (or Relevance) (be relevant), (5) The Maxim of Manner (be perspicuous, and specifically: avoid obscurity, ambiguity, be brief, be orderly (cf. Grice (1975:4)).

3. Critique of Grice's Conversational Principles

Grice's theory of Conversational Principles has been variously attacked, defended and revised by others. Keenan (1974) and Gazdar (1978:55) claim that Conversational Maxims are not universal because they are not so obviously applicable to some other languages. Brown and Levinson (1978:298–99) argue to the contrary. Gordon and Lakoff (1971) try to

formalise Grice's theory so as to fit it within a generative-semantics grammar. Lakoff (1973,1975,1977), and Brown and Levinson (1978) would place it within a larger model of sociolinguistic 'politeness'. Horn (1984:12) reduces the number of maxims, Sperber and Wilson (1986) reduce the maxims to the Principle of Relevance, which is criticised by Levinson (1989). Byrne (1992:18) emphasises that communication involves less co-operation than Grice assumes, and he proposes to replace Grice's CP with a Principle of rational Co-ordination. This principle, however, seems to be nothing else but a restatement of Grice's CP. Sarangi and Selembrouck (1992)) placed Grice's framework within experiential realism.

4. Grice's theory of implicature

In a series of influential and controversial papers (cf. Grice (1957), (1968), (1969)) Grice has argued that the meaning of a word in general is a derivative function of what speakers mean by that word in individual instances of uttering it. That is, the universal 'type' meaning, or set of such meanings, for a given word is an abstraction from the 'token' meanings that speakers use in specific instances. Grice proposes that what a word 'means' derives from what speakers mean by uttering it; and he further proposes that *what a particular speaker or writer means by a sign on a particular occasion may well diverge from the standard meaning of the sign* (cf. Grice (1957:381)). In other words, there is a distinction between the conventional or natural meaning of a word and its non-conventional or non-natural meaning. Although Grice's theory of non-conventional meaning is not generally treated as having any connection with his theory of implicature, Levinson (1983:101) suggests that, in fact, there is an important connection between them. According to Levinson (1983), non-conventional meaning was called an 'implicature' by Grice who deliberately coined this word to cover any non-conventional meaning that is implied, i.e. conveyed indirectly or through hints, and understood implicitly without ever being explicitly stated.

A few years after publishing his original paper on meaning, Grice sketched out a theory of pragmatic implication, distinct from semantic implication, as a tool for resolving certain linguistic problems in the theory of perception (cf. Grice (1975)).

Implicatures are not semantic inferences, but rather inferences based on the content of what has been said and some specific assumptions about the co-operative nature of ordinary verbal interaction. Thus, the Maxims or the Principles of Conversation generate inferences beyond the semantic content of the sentences uttered. Such inferences are, by definition, conversational implicatures and they will be determined by the intentions of the speaker.

5. Brown and Levinson's theory of politeness (FTA – positive and negative politeness strategies)

Brown and Levinson (1987) developed the notion of 'face', as crucial to understanding the theory of politeness. They define face as an emotional build-up, present in every person, by means of which interaction with others is carried out. If the interlocutor's face is lost or threatened, conversation becomes impossible. Thus, it is in the participants' interest to maintain each other's face. Everybody's face has two sides: positive and negative. Positive face is the desire to be admired and accepted by others. Negative face is the desire that no action be restricted by others.

Face threatening acts (FTAs) are acts that, by their very nature, run contrary to the face wants of the addressee and/or the speaker (cf. Brown and Levinson (1987:6)). Brown and Levinson (B/L) distinguish between acts that threaten the positive face and those that threaten the negative face. Therefore, they distinguished positive and negative politeness strategies.

According to Kopytko (1993:93), all pragmatic phenomena including politeness strategies are non-discrete, non-categorical, scalar and fuzzy in nature. Thus, problems with assignment to particular strategies of politeness frequently arise.

A linguistic-pragmatic account of doctor-patient communication (analysis of English sample material)

1. Discourse asymmetry

There are three models of doctor-patient relationship: the paternalistic model, the agency model and the consumer oriented model (cf. Kreps (1996), Vanderpool and Weiss (1984)).

In the paternalistic model the degree of asymmetry is the greatest since it is the doctor who is entirely in charge of the interview. In the agency and the consumer oriented models the asymmetry is reduced because the patient's free will and right to ask questions are respected.

2. Conversational maxims in English medical discourse (analysis of sample material)

All the strategies such as: the use of open or closed questions, phatic communication and topic transitions are related to the notion of relevance, if the latter is judged on the basis of the connectedness of purposes of doctors and patients (cf. Levinson (1987)).

Phatic communication directed at the needs of the patient, the use of open questions by doctors and reciprocal topic shifts contribute to the consumer and the agency oriented model of doctor-patient interaction in which the goals relevant to the patient are fulfilled, and both the positive and the negative face of a patient are respected by doctors (cf. Brown and Levinson (1987)).

Only in the consumer oriented approach to patients is there no dichotomy of goals between doctors and patients. According to Wienfield (1996), Coupland *et al.* (1994) and Ainsworth-Vaughen (1992), this is certainly the case in Australia, England and America. In Australia, open questions and the consumer oriented model of doctor-patient interaction are predominant in medical interviews. In England the majority of doctors pursue patients' private issues during medical interviews. Finally, in America doctors avoid unilateral types of topic transitions.

These findings suggest that the consumer oriented approach to patients is widespread in English speaking countries.

Doctors themselves are also not as informative as their patients would require. In fact, there is abundant evidence to suggest that current physicians in English speaking countries fail to supply consumers with satisfactory level of health information (cf. Kreps (1990), Hess, Liepman and Ruane (1983)). This implies that to become well-informed consumers need to actively seek out relevant health information from their doctors and a variety of other sources. The more informative in their explanations the doctors are, the better the result of the treatment. Thus, doctors should try to be as informative as possible even though, some patients do not ask for explanations directly.

Patients can also be underinformative, as in the example given by Coupland *et al.* (1994):

Patient (age 67, female); Doctor (male).
Doctor: Right, fine... um... how are you feeling now?
Patient: Not very well at the moment.
Doctor: Not well?
Patient: I have a cold and I in myself, I feel very bad.

Here, (given a scale <well, bad>) we derive a scalar implicature (cf. Levinson (1983)) that: as far as the patient knows she is feeling 'not very well' which implicates that it is not true that she is feeling 'very bad'. Later, however, the patient cancels the implicature by saying that she is, in fact, feeling 'very bad' and implicates the strongest statement on the scale. This suggests that the patient was underinformative when saying 'not very well'. Thus, she not only violated the Maxim of Quantity but also the Maxims of Quality and Relevance. She was not reliable in what she had said and was not informationally relevant.

The Maxim of Quantity can be violated in other ways. Aronsson and Sätterlund-Larrson (1987) suggest that doctors use long forms of address when they interview patients or when they want to regulate social distance and respect

patients' negative face (by minimising imposition and by being conventionally indirect) (cf. Brown and Levinson (1987)).

In some rare cases doctors do not give clear instructions but are polite by minimising imposition (using hedges e.g. 'a little'):

Doctor: You could perhaps undress a little and get on the couch and then we will examine you.

Patient: Shall I take everything off?

Thus, the doctor violates the Maxims of Manner (avoid ambiguity), Quantity (he is underinformative) and Relevance (he is not fully informationally relevant), but preserves the Politeness Principle, and by minimising imposition, he respects the patient's negative face (cf. Brown and Levinson (1987)). The doctor is also co-operative because the patient recognises his attempt to be polite (the doctor, by using a weaker statement 'a little' – a hedge – negative politeness – implies a stronger statement 'everything' – I-implicature (cf. Levinson (1987)) correctly arrived at by the patient). The doctor is co-operatively polite. Thus, one may suggest that the CP comprises the Principle of Politeness. The doctor violates the Principle of Quality to observe the Principle of Politeness. If there is a clash between the two principles the Politeness Principle may sometimes win, which suggests that the two principles are equally important and that they have the same place in the hierarchy of maxims.

To sum up, it is possible for both doctors and patients to be under or overinformative. One must also distinguish between the Maxim of Relevance in terms of the speaker's connectedness to his goals and the Maxim of Relevance in terms of the speaker's informational connectedness. It is clear on the basis of the above examples that whenever the speaker is over or underinformative, he is not fully informationally relevant, but he can still be relevant to his goals. Thus, there are two aspects of the Maxim of Relevance (one in terms of the connectedness of goals and the other in terms of the connectedness of purposes). Relevance in terms of the connectedness of goals is higher in the hierarchy of maxims since its violation makes effective communication almost impossible.

Grice's Maxims of Conversation in doctor-patient communication (analysis of Polish sample material)

1. Data and methods

The selection of doctors in this study includes fifteen internists, of which thirteen are females and seven are males working full time in two state hospitals

in Rzeszów, and part time in their private practice and out-patient clinics. The age range is from 28 to 55 years of age.

The data was obtained by means of in-person follow-up interviews with individual doctors conducted by the author. Five doctors agreed to have some of their interviews with patients recorded by means of a dictation machine. Others did not allow their appointment to be taped in order to maintain doctor-patient confidentiality. In sum, the author obtained forty recorded interviews, and in each case the patient was asked for permission to have his or her interview recorded by the doctor.

2.The Maxim of Relevance in Polish medical interviews

2.1. Explanations, reassurance and advice

Doctors can express empathy and compassion in a number of ways. Consider, for example, the following exchange:

Patient (age 57, female); Doctor (age 50, male); private practice.

(a) Doctor: Does your heart beat rythmically, now?
Patient: Yes.
Doctor: There are no changes on the EKG. Nothing dangerous is happening. Don't be concerned.

(b) Doktor: Czy to serce bije teraz równo?
Pacjent: Tak.
Doktor: W EKG nie ma zmian. Nic groźnego się nie dzieje. Proszę się nie przejmować.

Here, the doctor is reassuring the patient (positive politeness) that nothing dangerous is happening and is explaining to her (giving reasons – positive politeness) that there are no changes on the EKG. Thus, the doctor by being informative and empathic in his contribution, remains relevant to the patient's goal, respects her negative face (by using indirect constructions when talking to her) and positive face (by being optimistic) (cf. Brown and Levinson (1987)).

2.2. Phatic communication and open questions

In phatic communication doctors and patients pursue socio-relational goals. Phatic communication includes: summons, greatings, dispositional talk, familiarity sequences, holding sequences and 'how are you?' type of exchanges.

Consider, for example, the following conversation:

Patient (age 85, female); Doctor (age 28, female); hospital.

(a) Doctor: Where did it hurt?
Patient: In the back.
Doctor: In the back?

Patient: How long am I going to be here?
Doctor: You will lie here for a while. And why are you in such a hurry?
Patient: I want to go home.
Doctor: You want to go home. Why?
Patient: The cow is there.
Doctor: The cow is there? So, your son will take care of it.

(b) Doktor: Gdzie panią bolało?
Pacjent: Od tyłu.
Doktor: Od tyłu.
Pacjent: Długo tu będę?
Doktor: Trochę pani poleży. A czemu się pani tak spieszy?
Pacjent: Chcę iść do domu.
Doktor: Chce pani iść do domu. A czego?
Pacjent: Krówka została.
Doktor: Krówka została? No to syn się zajmie.

Here, the doctor investigates the patient's situation and is asking her private questions. This interest in the patient's private situation and respect for her positive face (cf. Brown and Levinson (1987)) on the part of the doctor is a sign of empathy (positive politeness). Moreover, the doctor expresses empathy by repeating the patient's exchanges. One may conclude, then, that the doctor tries to be relevant to the patient's goal (assuming that the patient expects an empathic approach).

3. The Maxim of Quantity in Polish medical interviews

3.1. Underinformative medical interviews (scalar implicatures, clausal implicatures, the principle of informativeness, R-implicatures)

Both patients and doctors can be underinformative. Patients are often underinformative in the explanations and descriptions of their illness. Doctors, in turn, may not provide their patients with sufficient explanations and information concerning the state of their health or treatment strategies.

The idea behind scalar implicature is that given a scale if the (S) asserts that a lower point holds, he implicates that a higher point (leftwards on the scale) does not obtain (cf. Horn (1972)). Consider, for example, the following extract:

Patient (age 46, male); Doctor (age 40, male); private practice.

(a) Doctor: Have you suffered from stomach illness? Have you got an ulcer?
Patient: An ulcer? No. But my stomach has been hurting me for several years all the time.
Doctor: What do you mean by 'all the time'? All day and also at night?
Patient: No, not at night.

(b) Doktor: Na żołądek pan chorował? Czy ma pan wrzoda?
Pacjent: Wrzoda? Nie. Ale żołądek boli mnie od kilku lat, boli mnie ciągle.
Doktor: To znaczy jak ciągle? Cały dzień i w nocy też?
Pacjent: Nie, w nocy nie.

Here, the patient implies that (given a scale <all the time, sometimes>) a lower point does not obtain. He is, however, underinformative because the higher point does not obtain either ('all the time' and 'not at night' are mutually exclusive). The patient, thus, is also not fully informationally relevant. He is violating the Maxims of Quantity, Relevance (in terms of informativeness), and Manner (he is ambiguous).

6. Conclusions

The analysis of Polish and English sample material shows that both doctors and patients can be over or underinformative and, thus, not fully informationally relevant. However, they may be relevant to their goals at the same time. This strongly suggests that there are two aspects of the Maxim of Relevance: the first one in terms of relevance to the (S's) or the (H's) goals and the second one in terms of informativeness or connectedness of information. The second aspect of the Maxim of Relevance limits the Maxim of Quantity (since, if violated, they are always jointly violated). The Maxim of Relevance being more abstract and complex, seems to be located higher in the hierarchy of maxims than the Maxim of Quantity. It is the supermaxim of Quality, however, which is the first in the hierarchy of maxims in medical discourse because it almost always has to be observed (especially by patients) if communication is to be efficient. It wins whenever there is a clash between it and the other maxims, except for the Principle of Politeness. Similarly, the Maxim of Manner should be treated as an independent one because it differs from the three other maxims in that it refers to the form and the way in which something is said, and not to the content. Moreover, the analysis carried out shows that Brown and Levinson's Principle of Politeness should be viewed as equal to the Maxim of Quality (it is the patient who expects to be treated with politeness and the doctor who expects truthfulness from the patient).

On the whole, Grice's framework should be viewed as an ideal scheme (not a realistic one) in which full co-operation between conversation participants is aimed at or approximated. To preserve the CP, then, one has to treat it as a guideline which can make communication more effective and which can be observed to a greater or lesser extent.

The Principles of Relevance and Quantity function a bit differently in the two cultures. In English language culture the goals of patients and doctors are the same, which makes their communication more effective. English speaking

doctors try to provide their patients with: (a) sufficient information; (b) they are empathic toward their patients; (c) they use open questions and raise social issues during medical interviews; finally, (d) they try to be polite and avoid obscure or ambiguous expressions. English speaking patients, in turn, try to be truthful and relevant in their answers to doctors' questions. In most cases they also respect their doctors' time by avoiding to provide them with totally irrelevant information. In sum, English speaking countries favour the consumer oriented approach to patients in which there is little or no dichotomy of goals between doctors and patients, and in which Grice's maxims tend to be observed.

In Poland, there is a dichotomy of goals between doctors and patients because Polish doctors work in a different reality than English doctors. The majority of health care services are cost free in Poland, which encourages people to overuse them. In other words, some people attend medical consultations more often than they need to, and as a result, doctors work under time pressure. In this situation, Polish doctors who work in state hospitals or state out-patient clinics do not have time: (a) to be empathic enough toward their patients, (b) to provide them with enough information, (c) to raise social issues during medical interviews and sometimes even to be polite. They violate the Maxim of Relevance and Quantity (and, thus, are less co-operative). They try not to use obscure and ambiguous language expressions. Polish patients, in turn, sometimes tend to be overinformative and vague in their explanations (they violate the Maxim of Quantity, Relevance and Manner). Polish doctors take the consumer oriented approach primarily in their private practice, and less often in hospitals and state out-patient clinics.

Moreover, the analysis of doctor-patient communication and specifically Grice's maxims in this type of interaction have proved Schiffrin's claim: *the analysis of function inevitably leads to the analysis of structure* (cf. Schiffrin (1994)). The most clear example supporting this statement comes from the analysis of the Maxim of Quantity and its implicatures which lead to the identification of scales and hedges. The patient to be truthful and informative employs certain characteristic structures (e.g. hedges). Similarly, the doctor to be polite uses indirect structures, reciprocal constructions, open questions and other devices.

To sum up, it is the goal of the patient to be truthful and relevant in his or her answers to the doctor's questions because that is what the doctor expects. The expectations of patients, however, are focused more on the doctor's handling of politeness phenomena in their interrelation with patients.

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