

Pragmatic corpus analysis of patient interviews in palliative care

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Abstract

This study examines communication by healthcare professionals (HCPs) with experience in palliative care (n= 24) and health sciences students (n=31) when raising difficult issues in patient-HCP encounters. Data was collected using a questionnaire, designed in collaboration with a palliative care nurse. Said data included demographic information, frequency of general communicative acts and the use of 8 politeness strategies when raising 7 difficult topics with patients. The findings were that HCPs use a greater number of positive politeness strategies and are also more likely to avoid performing the face threatening act entirely, that is, they were more cautious during patient encounters. This leads us to believe that through experience, the HCPs have learnt to be more cautious in patient interactions than their natural instinct, here represented by unexperienced students, would suggest. This is most likely due to the repercussions that a breakdown in communication could have on the patient's health outcomes.

Keywords: Politeness theory, End of life care, palliative care, patient communication, Face Threatening Acts, patient-HCP interactions.

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1. Introduction

Politeness theory (Brown & Levinson, 1987) describes the conventions of human interactions and examines how social distance, relative power and the perception of a given imposition in a given culture affect speakers' strategies when interacting with others. In this paper I will examine to what extent experienced palliative care professionals' linguistic behaviour conforms to the same norms as that of health sciences students when communicating with palliative care patients. The aim here is to establish if or to what extent personnel with training and experience in palliative care employ politeness strategies in a different way from individuals with comparatively very little specific training and experience (in this case, health sciences students). The idea behind this research is that, through experience repeatedly discussing recurrent, difficult issues concerned with end of life care, professionals are able to fine-tune their use of politeness strategies to maximise successful communication and avoid conflicts resulting from said discussions. By analysing the product of these years of experience, experienced healthcare professionals' behaviour could be emulated and taught in communication training designed for unexperienced professionals allowing them to raise difficult topics of conversation with a reduced risk of a breakdown in the relation with the patient.

The paper is structured as follows: Section 2 will present the theoretical framework assumed in this research. Section 3 presents the methodology of the study and subsequently, in Section 4, I will analyse the responses of healthcare professionals (hereforth HCPs) and students of medicine and nursing to a questionnaire designed to examine their use of politeness strategies in patient encounters revolving around so-called difficult issues and discuss the implications of the results. Final conclusions will be provided in Section 5.

2. Theoretical framework and the context of the study

2.1 Politeness Theory

Brown and Levinson's (1987) work established a framework which links linguistic behaviour to our anthropological development. Their theory states that people are rational beings governed by two wants which together constitute our *face*. These wants are 1. to be considered as a part of the group or to be approved of (positive face) and 2. to be free and unimpeded by others (negative face). We are also able to attribute these wants to others and when we wish to perform a Face Threatening Act (FTA), we dispose of a set of (not necessarily conscious) strategies which allow us to lessen the risk represented by a given FTA and strive to maintain social harmony. The theory operates on the basis that interlocutors are rational beings who are able to pre-empt possible FTAs and adapt their speech accordingly. That is to say, when a speaker is going to perform an FTA which threatens the negative face of the hearer, they will do so employing an appropriate number of negative politeness strategies in order to reduce the risk of creating a conflict with the hearer. The same can be said for positive politeness strategies which are employed where there is a threat to the hearer's positive face.

The use of politeness strategies in a given situation also depends on three sociological factors: social distance, relative power and the ranking of a given imposition in a given culture. Social distance (D) is defined as the frequency of interactions and nature of material or non-material goods (including face) exchanged between two interlocutors; it is symmetrical relationship between speaker and hearer and is often based on reciprocal giving and receiving of positive face. Relative power (P) is defined as control over material or metaphysical aspects of H's existence. The absolute ranking of a given imposition (R) depends on the culture and the immediate context, according to their intra-culturally assigned ranking of a given FTA depending on the expenditure of services

(which can include time) and goods (which can include information or face payments). In order to elucidate these terms, we can imagine someone asking the question “*how much do you earn?*”. We can envisage that the question could be asked frankly between old friends because the social distance is not very big, whereas if the same question were asked by a stranger on a train, it is likely to cause offense on behalf of the hearer. Similarly, if this question is asked by your boss, who has high power relative to you, you are more likely to respond than if the same question is asked by a colleague of your rank, who here has little/no relative power over you. Finally, some world cultures may consider the topic of money to be taboo meaning that the ranking of the FTA in these cultures is greater than in others. Where social distance is great, relative power is low or the imposition is considered significant, more redressive action is required to perform a given FTA than where social distance is small, relative power is high and the imposition is not considered to be sizeable. (Redressive action here refers to means of awarding face to the hearer to counterbalance the threat of the FTA)

Despite proposals for adjustments to details of the theory, Brown and Levinson’s work is still widely accepted by linguistics today. Although there are objections to their assertions of universality and their definition of context are among the most prevalent (Davies, Haugh, & Merrison, 2013; Watts, 2003) for the purposes of this paper, we will not enter into details of the arguments included in literature subsequent to the original theory. The original work on politeness theory describes a range of strategies employed by a given Speaker (hereforth S) when performing an FTA to a Hearer (hereforth H). Said strategies fall into three main categories: positive politeness strategies, negative politeness strategies and off the record strategies. This study examines the use of five positive politeness strategies and four negative politeness strategies which are exemplified below.

Positive politeness strategies:

- *Use of in-group identity markers (examined in section 1 of the questionnaire)*
 - use of T honorifics (term coined by Brown & Gilman, 1960) or ‘tuteo’
 - use of the first name when addressing patients.

This politeness strategy is used to convey a sense of membership to the same social group, demonstrating that the speaker perceives a low social distance between themselves and the hearer.

- *Seek agreement*

1. **Is it ok with you** if I introduce you to him next time?

This strategy is another way of claiming common ground with the interlocutor. It involves obtaining the hearer’s agreement with what you are saying, potentially by repeating the hearer’s ideas back to them or asking ‘safe’ questions.

- *Give reasons*

2. **...I am asking because we have a social worker at our disposition who could help you.**

By stating the reasons behind an FTA, the speaker is able to make it seem more reasonable, in an attempt to justify it to H.

- *Offer or promise*

3. **...I’m here and if I can help you, count on my help.**

In order to reduce the threat that a given FTA represents, the speaker can emphasise other ways in which they are willing to cooperate with H to protect his/her wants.

- *Assert or presuppose knowledge of and concern for H’s wants.*

4. **I understand that you are overwhelmed by the situation and want to find a solution as soon as possible.**

S can put pressure on H to accept an FTA by asserting or implying knowledge of H’s wants and demonstrating S’s desire to comply with them.

Negative Politeness strategies:

- *Be conventionally indirect*

5. You seem sad lately and **I was wondering if** you would like to talk about the matter.

Conventionalised indirect expressions such as indirect questions, which is what was examined in this study, encode S's wants in an unambiguous way but provides a compromise of being partially on record and partially off record.

- *Question, hedge*

Hedged performatives (Fraser, 1975; Lakoff, 1973)

6. **I don't know if** it would be useful for you...

Hedged performatives add a sense of uncertainty or subjectiveness to the speech act that they precede.

Hedging

7. **Perhaps** it would be useful for you...

Hedges reduce the definitiveness or absoluteness of a given expression. They are often adjectives or particles, which give a sense of partial membership or partial truth.

Question

8. **Would it be useful for you...?**

Questions can disguise FTAs such as requests or suggestions without obliging the speaker to take ownership of the FTA.

- *State the FTA as a general rule*

9. **There are patients who, in circumstances like yours, say...**

This strategy moves the FTA away from the interlocutors and describes a hypothetical or generic S and H.

- *Impersonalise S and H: avoid pronouns I and you*

10. **We** don't have a good prognosis.

This strategy was examined through the use of the inclusive 'we'. By pluralising the first person pronoun the speaker demonstrates respect for H and membership of the same group.

Those who are perceived to successfully perform an FTA without causing offense or a breakdown of the conversation, are often said to have interpersonal skills (McConnell, 2004); Argyle, 1994). Said skills have been given a growing importance for medical professionals in their interactions with patients (Barakat, 2007, Cämmerer, Martin, & Rockenbauch, 2016). Nevertheless, communication skills are often taught on the basis of psychological techniques, and linguistic or anthropological concepts like politeness strategies are not explicitly included (Robins & Wolf, 1988). It has however long been considered that the explicit mention of politeness theory in training about communication skills could give HCPs a stronger tools and conceptual understanding of the mechanisms of communication, allowing them to better improvise in unforeseen or unprecedented contexts (Robins & Wolf, 1988).

2.2 Palliative care and the peculiarity of patient-HCP encounters

Palliative care is a relatively new field of medicine in Spain, starting in just the 1980s (Centeno Cortés, 1995) but given a growing need for palliative care in a developed world with an ageing population (Sepúlveda, Marlin, Yoshida, & Ullrich, 2002), it is a service which will grow in importance in years to come.

HCPs may feel compelled to pose questions or raise topics which represent an FTA that may be avoided by other interlocutors (friends, family etc). This is due to the unique dynamic between HCPs and their patients when they assume these roles (Robins & Wolf 1988); it is a temporary relationship where both parties fulfil a well-defined role that is not related to their life outside of the healthcare context. As such, the social distance (D), relative power (P) and perception of the imposition (R) are peculiar to this interaction. Many difficult topics must be raised as part of the duty of care of the HCP.

Given their high P in patient encounter, HCPs should be able to perform an FTA with little or no redressive action. Nevertheless, it is likely that experienced HCPs have witnessed a breakdown in their relationship with the patient due to the extreme nature of difficult topics in palliative care. Given their role, HCPs may feel duty-bound to raise difficult topics with patients or family members which “in a non-clinical context would be a highly dispreferred type of speech act” (Steel, Hodgson, Stirling, & White, 2014) but in doing so they may need to bear in mind consequence for the future of their relationship with the patient and potential repercussions for the patient’s care.

According to Brown and Levinson’s 1987 theory, where one chooses to perform an FTA, politeness strategies are employed in order to maintain social harmony. When we consider that the relationship between the HCP and their patient has been strongly linked to patient compliance with medical advice (Ha & Longnecker, 2010; Ridd, Shaw, Lewis, & Salisbury, 2009; Robins & Wolf, 1988), understanding the strategies employed by experienced clinicians to successfully navigate complex conversations about inherently conflictive or emotional issues could be instrumental in improving communication training/strategies for trainees in this evolving field of healthcare.

3. Methodology

3.1 Designing the questionnaire

In order to identify difficult questions or concerns which HCPs discuss with their patients, an interview was carried out with a Palliative Care Nurse with 9 years' experience. In said interview she was asked to explain the format of a standard encounter with an in-patient in a Spanish palliative care unit. She was then asked to outline topics which she may find difficult to bring up with a patient. The findings were that themes which may cause suffering for a palliative care patient such as family issues, economic matters or questions regarding the future of their disease were the most complicated to discuss. Seven possible interactions between an HCP and a patient that could involve an FTA were replicated on the basis of the nurse's responses:

1. You consider it advisable that a terminally ill patient make arrangements for the future of her children.
2. You would like to suggest that a patient continue discussing their economic situation even though they are clearly getting emotional and starting to cry.
3. You would like to ask a patient if they would like to speak to a spiritual advisor.
4. You have to inform a patient that their illness is more complicated than first suspected.
5. You think a patient may be suffering from the Wish to Hasten Death as defined by Balaguer et al. (2016). You would like to bring the matter up with the patient to give them a change to talk about it.
6. You have to tell a patient that they you are not going to continue with further sessions of chemotherapy.
7. You have to a respond to a patient asking how long they are likely to live for. It is unlikely that they will survive until the date they are asking about.

Questions 1, 2 and 3 are FTAs because they involve raising a highly emotional topic, questions 4 and 7 represent bad news about H, question 5 involves mentioning a taboo topic and question 6 involved blatant non-cooperation with H's wants. All of the above are considered to be intrinsic FTAs (Brown & Levinson, 1987)

These seven scenarios were then described for the questionnaire and questions about how the HCP would address the situation were included. The above were then presented to a palliative care doctor and nurse and their feedback was taken into account.

After minor adjustments were made to ensure that the scenarios were realistic, Section 1 of the questionnaire was developed to collect demographic information and data about the following communicative acts:

- Use of T honorifics or so-called ‘tuteo’
- Use of the patient’s first name
- Introduce yourself with a handshake, stating your job title on the first visit
- Ask permission to enter the patient’s room
- Speak in a private place where no one can overhear
- Ask the patient who they would like to be present
- Ask generic questions / make small talk before the clinical interview
- Ask permission before discussing difficult topics
- Explicitly offer to discuss any issues or concerns the patient may have
- Ask if the patient needs anything else before you leave
- Explicitly say goodbye to the patient

The final version of the questionnaire is included here as annex 1.

3.2. Dissemination

The questionnaire was disseminated as an open-access link to a Google Form. It was sent to HCPs with experience in palliative care in Spain by means of a mailing list from WeCare Chair: End of Life Care, a research group working in the area of palliative care at the Universitat Internacional de Catalunya, and to medical students at the Universitat Pompeu Fabra and to medical and nursing students from the Universitat Internacional de Catalunya by contacting with the academic faculties and asking them to pass on information about the study along with the link to the questionnaire to their students. Participants were encouraged to pass the link on to their peers or other potential participants in order to maximise data collection. An email address was included at the beginning of the questionnaire in order to allow potential participants to express doubts or ask questions about the study. No contact details were collected in the questionnaire to assure the anonymity of the responses. After one week a kind reminder was sent to potential participants via email in order to encourage participation in the study. After two

weeks the link was taken off-line and no further responses were accepted. Before completing the questionnaire, willing participants were required to give their consent to the anonymous use of the responses they provided for the purposes of this study and potential related research in the future.

4. Results and discussion

A total number of 55 responses were received. The responses to the questionnaire were separated into HCPs (n=24) and health sciences students (n=31). The data analysis for sections 1 and 2 of the questionnaire was performed separately. Data from Section 1 of the questionnaire (concerning demographic information and general communicative behaviour) were analysed statistical calculations by means of the programme SPSS whereas the written responses from Section 2 (concerning the seven possible interactions between HCP and patient) were first adjudicated a score for the presence of 8 politeness strategies. These scores were subsequently analysed using SPSS. The details of this analysis will be presented in section 4.1.

4.1 Questionnaire results

4.1.1 General communicative behaviour

Section 1 of the questionnaire aimed to gain an insight into the participants' background and assess some general aspects of the communicative behaviour of both populations.

The HCPs (n=24) who responded to the questionnaire included nurses (n=13), psychologists (n=8), social workers (n=2) and doctors (n=1). 45.8% of the HCPs who participated had over 5 years of experience in palliative care and all at least 1 year of experience. The health sciences students (n=31) who responded to the questionnaire included medical students (n=27) and nursing students (n=4). As students, they had no previous hands-on experience in palliative care, 4 students stated that they had completed placement in palliative care units of less than 6 months in duration. In both populations there was an imbalance in the male and female participants with 16.7% of HCPs and 35.5% of students being male.

Participants were asked to state the frequency with which they perform a series of communicative acts when visiting an in-patient. The frequencies they indicated were then converted to numerical scores according to the following scale:

- Never → 1
- Seldom → 2
- Sometimes → 3
- Usually → 4
- Always → 5

The results are displayed in the table below, significant differences are marked in bold:

Table 1 - frequency scores for communicative acts

Communicative act	Mean score for HCPs	Mean score for students	Median score for HCPs	Median score for students
Use of T honorifics or so-called ‘tuteo’	2.8 <i>≡ sometimes</i>	2.3 <i>≡ seldom</i>	3 = <i>sometimes</i>	2 = <i>seldom</i>
Use of the patient’s first name	3.8 <i>≡ usually</i>	3.6 <i>≡ usually</i>	4 = usually	4 = usually
Introduce yourself with a handshake, stating your job title on the first visit	4.8 <i>≡ always</i>	4.7 <i>≡ always</i>	5 = always	5 = always
Ask permission to enter the patient’s room	4.5 <i>≡ always</i>	3.9 <i>≡ usually</i>	5 = always	5 = always
Speak in a private place where no one can overhear	4.5 <i>≡ always</i>	4.5 <i>≡ always</i>	5 = always	5 = always
Ask the patient who they would like to be present	3.6 <i>≡ usually</i>	3.1 <i>≡ sometimes</i>	4 = usually	3 = sometimes
Ask generic questions / make small talk before the clinical interview	4.7 <i>≡ always</i>	4.3 <i>≡ usually</i>	5 = always	5 = always
Ask permission before discussing difficult topics	4.5 <i>≡ always</i>	3.7 <i>≡ usually</i>	5 = <i>always</i>	4 = <i>usually</i>
Explicitly offer to discuss any issues or concerns the patient may have	4.6 <i>≡ always</i>	4.0 <i>≡ usually</i>	5 = <i>always</i>	4 = <i>usually</i>

Ask if the patient needs anything else before you leave	4.6 \equiv always	4.6 \equiv always	5 = always	5 = always
Say goodbye to the patient	4.7 \equiv always	4.8 \equiv always	5 = always	5 = always

Comparisons were then made between the frequency scores of HCPs and the students for each item in the list. Given that the data was not normally distributed, this was done using a Mann Whitney U test with the aim of verifying whether there were significant differences in the frequency scores between the two groups. There was found to be a significant difference in the frequency scores for the use of T honorifics by HCPs and students (Median=3 vs Median=2, respectively; $U = 252.0$, $z = -2.134$, $p = 0.033$). This indicates that HCPs make significantly more use of T-forms than the students. The more widespread use of less formal verbs forms or ‘tuteo’ by HCPs is a manifestation of the positive politeness strategy *use in group identity markers*. This could be an indicator of a desire to reduce the patient’s perception of D between themselves and the HCP, creating a closer, more informal relationship (Agha, 1994; Friedrich, 1975). Although it could be considered that the mean age of the students was likely to be lower than that of the HCP population, which could have contributed to the disparity between the two scores. Nevertheless age and other macro-sociological factors are thought to have a comparable or lesser value than interactional stances or other factors unique to a given dialogue (Silverstein, 1988; Wales, 2008). That is to say, age alone is unlikely to account for the difference in scores between the two groups. Participants were asked to state any factors that influence their choice of *tú* forms, the results show that less importance was given to the patient’s age than to the relationship with the patient by experienced HCPs (relationship to patient: 37.5%; age: 20.8%; patient’s request: 20.8%; obtaining prior permission from the patient: 12.5%; type of patient: 4.17%). And, although students, at least consciously considered age to be the most important factor, they also recognised the

influence of other factors (age: 58.0%; patient's request 35.4%; relationship to patient: 19.4%, having to give bad news: 6.5%, patient's emotional state: 3.2%,). The fact that both populations recognised other important factors in the use of T-forms tends to support Silverstein and Wales' assertions that each interaction has a unique set of factors which determine the use of familiar or formal verb forms. This supports the idea that over time, experienced HCPs are able to adapt their use of T-honorifics to the specific context of an in-patient palliative care encounter.

There was also found to be a significant difference between the frequency with which HCPs and students *ask permission before discussing difficult topics* (Median=5 vs Median=4, respectively; $U = 217.5$, $z = -2.776$, $p = 0.006$) and *explicitly offer to discuss any issues or concerns the patient may have* (Median=5 vs Median=4, respectively; $U = 248.0$, $z = -2.295$, $p = 0.022$). The significant difference between whether HCPs or students would ask permission to discuss a difficult topic or explicitly offer to discuss a difficult topic could be represent a desire to make up for an imbalance in relative power (denoted by P in Brown and Levinson's theory) between the patient (low P) and the HCP (high P) by giving the patient the opportunity to refuse their permission or the offer. As noted previously, the relationship between an HCP and a patient is peculiar in many senses meaning that the values of social distance (D), relative power (P) and perception of the imposition (R) are also unique to this interaction. Many difficult topics may be raised as part of the duty of care of the HCP. Given their high P in patient encounter, HCPs are able to perform an FTA with little or no redressive action. Nevertheless, given the negative impact on patient outcomes that can result from a breakdown in the relationship between a may make them wary of performing FTAs, thus employed a greater number of redressive measures. Explicitly offering to discuss a difficult topic or asking permission before bringing something up provide the patient with the opportunity

to ignore the offer or refuse permission, therefore protecting their negative face in the sense that they are not imposed upon and removing the potential threat to their positive face that would occur if they were to refuse to respond to a bald, on record question. This use of an offer or request for permission here constitutes redressive action. Although it must be noted that despite constituting an off-record strategy in these cases, both an offer and a request for permission are in and of themselves an FTA for the patient; Brown and Levinson (1987) include both offers and requests in their list of intrinsic FTAs.

There were found to be no significant difference between the two populations in terms of the remaining communicative acts. This is likely to be because the students, despite having very little or no experience in palliative care, are still able to recognise the potential FTAs for the patients and apply some kind of redressive action. Where significant difference were found (i.e. in the use of T-forms, asking permission to discuss difficult topics and offering to discuss difficult topics) we could consider that the behaviour of the HCP has been modified in accordance with their experience. Both the use of the tuteo and the use of offers and request for permission represent redressive action by which the experienced HCP protect the face wants of the patient in order to avoid a breakdown in the conversation and potential consequences for the future of the relationship with the patient.

4.1.2 Difficult Patient-HCP Interactions

Section 2 of the questionnaire presented the participants with seven scenarios inspired by the initial interview with an experienced palliative care nurse. On the basis of the nurse's explanations of her experiences of patient encounters, seven difficult scenarios were identified and classified according to the kind of FTA they represented. These scenarios were described by the experienced nurse as being both difficult issues to raise and recurrent situations in clinical practice (see annex 1 for a copy of the questionnaire).

The participants were asked to respond as if they were speaking to a patient, that is, in direct speech. A number of answers were disregarded because they were not written as though they were spoken; the exact number of responses included for each of the seven questions is reported below. Answers were then coded for the presence of the following strategies (adapted from Robin & Wolf, 1998, see Section 2.1 for examples):

Table 2 - politeness strategies analysed in questionnaire responses

Politeness strategy	Type of politeness
Be conventionally indirect	Negative
State the FTA as a general rule	Negative
Impersonalise	Negative
Question, hedge	Negative
Seek agreement	Positive
Give reasons	Positive
Show concern for H's wants	Positive
Offer to talk / help	Positive
Do not perform FTA	-

Numerical values were assigned to the results in order to facilitate statistical analysis. For the above strategies, a score of 0 or 1 was assigned to each response for each strategy, where 0 corresponds to the absence of this strategy in the response and 1 to the presence of the strategy in the response. An overall score for negative politeness and for positive politeness was then calculated for each response out of a possible score of 4.

Once the answers had been assigned a score, a statistical analysis was carried out. The first stage of the analysis was to examine whether there were significant differences between the overall score for positive politeness and negative politeness in the two populations. Due to non-normal distribution of the data, this was done using a Mann

Whitney U test for the set of answers from both populations for each question. Further analysis was then performed using a chi-squared test to identify significant differences in the use of individual strategies. The chi-squared test was used here because the data contained just two possible values per participant: 0 or 1. The median overall negative and positive scores for each population are displayed in the table below along with an indication of significant differences (Sig.Dif):

Table 3 - overall positive and negative politeness scores

	Negative politeness score (0-4)		Positive politeness score (0-4)	
	Median score	HCP	Median score	student
Question 1	1		1.5	1
Sig.Dif for question 1	None		Significant difference	
Question 2	1		2	1
Sig.Dif for question 2	None		Significant difference	
Question 3	0		1	0
Sig.Dif for question 3	None		None	
Question 4	0		0	1
Sig.Dif for question 4	None		None	
Question 5	0		0	0
Sig.Dif for question 5	None		None	
Question 6	0		1	1
Sig.Dif for question 6	None		None	
Question 7	0		0	0
Sig.Dif for question 7	None		None	

The table below shows the percentage of HCPs (H) and students (S) who employed each strategy in their responses to each question. Significant differences in the scores for the preceding question are indicated in the row entitled Sig.Dif. The percentages do not necessarily add up to 100 because many participants employed multiple strategies.

Table 4 - scores for individual politeness strategies

	Indirect question (%)		FTA as a rule (%)		Inclusive we (%)		Question/hedge (%)		Seek agreement (%)		Give reasons (%)		Assert or presuppose concern (%)		Offer/promise (%)	
HCP/Student	H	S	H	S	H	S	H	S	H	S	H	S	H	S	H	S
Question 1	0	0	6	7	13	11	50	33	25	22	31	7	44	4	50	48
Sig.Dif.	N/A		N/A		N/A		None		N/A		N/A		N/A		none	
Question 2	0	0	19	35	13	15	56	12	50	12	31	4	63	23	63	38
Sig.Dif.	N/A		N/A		N/A		N/A		N/A		N/A		Significant		none	
Question 3	6	10	33	34	0	10	6	24	6	0	11	14	17	3	56	34
Sig.Dif.	N/A		None		N/A		N/A		N/A		N/A		N/A		none	
Question 4	0	0	0	0	16	7	16	43	26	14	0	0	5	25	26	43
Sig.Dif.	N/A		N/A		N/A		None		N/A		N/A		N/A		none	
Question 5	0	7	17	18	0	4	28	11	11	4	0	0	0	4	6	14
Sig.Dif.	N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A	
Question 6	0	0	0	7	33	19	20	15	27	15	33	63	7	30	13	19
Sig.Dif.	N/A		N/A		N/A		N/A		N/A		none		N/A		N/A	
Question 7	0	0	20	7	0	4	15	43	0	0	5	7	10	4	0	4
Sig.Dif.	N/A		N/A		N/A		significant		N/A		N/A		N/A		N/A	

In the table above, *significant* corresponds to a significant difference between the HCP and student scores for the strategy scores for that question. *None* denotes no significant difference and *N/A* denotes an inconclusive result from the chi-squared test. Given that there were 4 counts in the table for the chi-squared tests in this study (1. HCPs who employed the strategy, 2. HCPs who did not employ the strategy, 3. students who employed the strategy and 4. students who did not employ it) no count could be less than 5 as this could represent more than 20% of the counts having a total of less than 5 which renders the chi-squared test impossible (Yates, Moore, & McCabe, 1999).¹

¹ Therefore, inconclusive results appear where one or more of the following statements was true for a given strategy and a given question:

- Fewer than 5 HCPs employed the strategy
- Fewer than 5 HCPs did not employ the strategy
- Fewer than 5 students employed the strategy
- Fewer than 5 students did not employ the strategy

A greater sample size would be necessary in order to achieve at least 5 participants in each of the above categories for every question and every strategy. Once these criteria are fulfilled, the chi-squared test would provide us with conclusive results regarding significant differences in the scores of each population for all strategies in all questions. Each question is discussed individually below.

Question 1- the future of the patient's children

(HCPs (n=16); student (n=27))

For question 1, there was found to be a significant difference in the overall positive politeness score between HCPs and students (Median = 1.5 vs Median = 1, respectively; $U = 133.5, z = -2.187, p = 0.029$). This shows that the HCPs used more positive politeness strategies than the students when discussing the future of the patient's children. By contrast, there was no significant difference in the overall negative politeness scores of the two groups. The table below shows typical responses from both groups. Manifestations of the 4 positive politeness strategies included in the study are shown in bold.

Table 5 – examples of questionnaire responses to question 1

Typical answers – HCPs	Typical answers – students
María, como sabes las cosas no van demasiado bien, por prevención y para no preocuparte si no te encuentras bien (GR, SC), creo que ahora es el momento adecuado para poder decidir quién se hará cargo de los niños, ellos necesitaran un apoyo (GR), un guía cuando las cosas se compliquen, piénsalo, mañana hablamos. Si le parece podemos (AG) reunirnos, tú y tus hijos y alguna persona de confianza con la trabajadora social.	Sr/Sra.... ¿ vería usted conveniente que (AG) le indicase los medios con los que usted cuenta para planificar en la medida de lo posible el futuro de sus hijos?
Me gustaría hablar con usted dada la situación que presenta; es la cuidadora principal de 2 hijos menores de edad y decirle que podríamos ayudarle para	Le pondremos en contacto con un trabajador social que valorará su situación

garantizar que sus hijos están bien cuidados (OP). Existe la figura del trabajador social, figura que le podrá asesorar sobre los derechos que tiene. Podríamos proponer(OP) una visita con ella, y en la entrevista resolver cualquier duda que tenga(GR). ¿Le parece?(AG)	actual y tratará de ayudarla tanto a usted como a sus hijos
¿Hay algún aspecto que le preocupe en relación a sus hijos? Si quiere podemos hablar de ello(OP) En nuestro equipo contamos con un trabajador social que le puede ayudar respecto a sus preocupaciones(SC) , así como asesorar sobre qué medidas pueden ser útiles. ¿Qué le parece si se lo presento el próximo día?(AG)	Tenemos mucho trabajo por hacer... puede venir un trabajador social/experto para asesorarle en todo lo que necesite.

Key: GR – give reasons
 OP – offer / promise
 SC – presuppose or assert knowledge of / show concern for H's wants
 AG – seek agreement

Further analysis of the scores for the individual strategies using a chi-squared test showed that there was no significant difference in the use of the following negative politeness strategies: *indirect questions* and *question/hedge*. This was unsurprising given the lack of significant difference in the overall negative politeness scores in the two groups. There was also found to be no significant difference in the use of the positive politeness strategy *offer/promise*. This suggests that the significant difference between the overall positive politeness scores of the two groups revealed by the Mann Whitney U test originated from a difference in use of one of more of the remaining 3 positive politeness strategies included in this study. However, the chi squared test showed no conclusive results for the other 2 negative politeness strategies and 3 positive politeness strategies (*state the FTA as a general rule, inclusive we, seek agreement, give reason, assert or presuppose concern for H's wants*). This is because the data for these 5 strategies did not fulfil the aforementioned requirement of the chi squared test of having no fewer than 5

individuals for each count in the table. Generalisations about the difference in the use of these strategies by the two populations are therefore not possible at this stage.

The above results shows that HCPs adopt a greater number of positive politeness strategies when discussing the future of their patients' children than the students. This indicates that experienced HCPs are more cautious about their approach to possible FTAs than their student counterparts. This reinforces the conclusions made with regards to the increased frequency of requests for permission and offers before discussing difficult topics by HCPs in the section 1 data.

Question 2- economic situation of a crying patient (HCPs (n=16); students (n=26))

There was found to be a significant difference in the positive politeness score of HCPs and students when suggesting that the crying patient continue to discuss their economic situation (Median = 2 vs Median = 1, respectively; U= 65.0, z= -2.187, p= 0.029). This coincides with the findings from question 1 as it shows that the HCPs employ a greater number of politeness strategies than the students. There was no significant difference in the negative politeness scores of the two groups.

Table 6 - examples from the questionnaire responses to question 2

Typical answers – HCPs	Typical answers – students
Sé que es un tema difícil de tratar (SC). No obstante, usted sabe que estoy aquí para ayudarle en lo posible(OP). Si usted lo prefiere(AG) puede hablar con un familiar o con un experto en el tema.	Veo que hablar de este tema le genera tristeza y preocupación. ¿Piensa que es bueno para usted hablarlo o prefiere dejarlo aquí?
Sé que muchas veces es difícil hablar sobre este tema (SC) ya que puede implicar a muchas personas pero quizás le vendrá bien (GR) hablarlo con alguien ajeno a la situación, si quiere le doy cita para otro día (OP) cuando haya meditado sobre el tema.	¿Quiere que sigamos hablando sobre este tema? ¿Cree que puedo ayudarle?

Key: GR – give reasons
OP – offer / promise
SC – presuppose or assert knowledge of / show concern for H's wants
AG – seek agreement

There was found to be no significant difference in HCPs and students' use of *offers/promises*. This analysis did not provide conclusive results for the other variables (*indirect questions, state the FTA as a general rule, inclusive we, question/hedge, seek agreement from H, give reasons*) due to the data not fulfilling the requirements of the chi-squared test. The results of the chi-squared test did show that in addition to a significant difference in the overall positive politeness scores of the two groups with HCPs using more politeness strategies in their responses, there was a significant difference in the score for *asserting or presupposing knowledge of and showing concern for the patient's wants* ($p=0.011$, $\chi^2=6.528$) with HCPs using this strategy more often than the students. This hints that experienced HCPs feel it is better to demonstrate to the patient their concern for their wants as a way of redressing the FTA. The higher overall positive politeness score could represent a way of reducing social distance, which is largely defined by the exchange of positive face (Brown & Levinson, 1987). The following is a typical answer from an HCP including assertions and presuppositions about the patient's wants:

*“Sr. X, por lo que me cuenta puedo ver que su situación no es fácil y **quiere arreglar estos problemas**. Me imagino que le preocupa y **le gustaría hablar con alguien del equipo para encontrar una solución lo antes posible**. Si quiere, me puede explicar la situación con más detalle, así sabré a quién acudir para que nos ayude.”*

Question 3- spiritual advisor (HCPs (n= 18); students (n=29))

There were found to be no significant differences in the overall positive and negative politeness scores of the two populations when asking whether a patient would like to see a spiritual advisor.

Further analysis of the scores for individual strategies showed there was no significant difference in the scores of HCPs and students for the use of the strategies:

stating the FTA as a general rule and making offers or promises. The data for the other strategies could not be analysed as data did not conform to the requirements of the chi-squared test.

Question 4-*bad news about the patient's illness* (HCPs (n=19); students (n=28))

There were found to be no significant differences in the overall positive and negative politeness scores of the two populations in their responses to question 4.

Closer analysis by means of a chi squared test of the scores for individual strategies in both populations showed no significant differences in the scores for *questioning/hedging, giving reasons for the FTA and offers/promises.* The other strategies could not be analysed because the sample did not fulfil the requirements for the chi-squared test.

Question 5- *asking about the Wish to Hasten Death* (HCPs (n=18); students (n=28))

There were found to be no significant differences in the overall positive and negative politeness scores of HCPs and students in question 5.

No further analysis was possible through chi squared tests for the data from question 5 because data did not fulfil the criteria necessary for this test.

Question 6- *refusing further chemotherapy* (HCPs (n=15); student (n=27))

There were found to be no significant differences in the overall positive and negative politeness scores of the two groups for question 6.

No significant differences were discovered between the scores of HCPs and students for the use of the strategy *give reasons for the FTA* in question 6. The scores of the two populations for the remaining strategies could not be tested using the chi-squared test as the data did not fulfil the aforementioned criteria.

Question 7-bad news about the patient's estimated life span(HCPs (n=20); student (n28))

There were found to be no significant differences in the overall positive and negative politeness scores of the two populations in their responses to question 7.

Closer analysis by means of a chi squared test of the scores for individual strategies in both populations showed a significant difference in the scores for *question/hedge*, ($p=0.04$, $\chi^2=4.214$). This reflects a significantly higher use of *questions/hedging* by the students as compared with the HCPs. This could correspond to a desire to reduce ambiguity overriding the desire to reduce the FTA by experienced HCPs in this extreme case of bad news. Some typical response from each group are included in the table below. Fragments of text representative of questioning or hedging are highlighted in bold.

Table 7 - examples of questionnaire responses to question 7

Typical examples –HCPs	Typical examples –students
Insisto en que podemos equivocarnos porque cada persona es distinta, es que, personas con enfermedades como la suya, no suelen vivir más de un año. Lo cierto es que su estado de salud es frágil... y pase lo que pase, estaremos a su lado para acompañarle y tratar todos los síntomas o complicaciones que puedan aparecer... sea cuando sea	La enfermedad no ha respondido como pensábamos al tratamiento, y aunque seguiremos trabajando con usted para conseguir los objetivos que nos vayamos planeando, es posible que (H) esto que usted plantea esté un poco (H) fuera de nuestro alcance. Lo importante es que usted quiera seguir trabajando por su salud y vivir lo mejor posible mientras lo hacemos.
Me gustaría responderle que sí, pero le estaría engañando. La enfermedad avanza, y la situación es difícil, tiene que estar preparado por si las cosas no van bien, y la situación se acelera...podemos mirar de adelantar lo que quiere hacer antes.	No le puedo dar una respuesta acertada. Me temo que (HP) el pronóstico no es bueno, pero cada persona es un mundo, y no es posible dar fechas con seguridad (H) . ¿Entiende a qué me refiero?
Aunque no podemos saber exactamente el tiempo de vida, sí que le puedo decir que su enfermedad está en un estadio grave y que es posible que estemos hablando más de meses que de años.	A esa pregunta no podemos responderle nada concreto (H) . El curso de su enfermedad parece ser (H) que se ha acelerado pero eso no nos permite indicarle un momento particular. No obstante, el pronóstico no es bueno(H) , veremos día a día como se encuentra. Intentaremos que esté lo más confortable posible con su enfermedad.

Key: H – hedge
HP – hedged performative

4.1.3 Refusal to perform the FTA

A secondary analysis was carried out on the responses which were coded as not containing the potential FTA. According to Brown and Levinson's theory, where the want to maintain H's face to any degree is greater than the want to communicate the FTA, the speaker will opt not to perform the FTA.

The percentages of each population who did not perform the FTA alongside the significant difference found in the chi-squared test is displayed in the table below:

Table 8 - responses where the FTA was not performed

	Percentage of participants who did not perform the FTA	
	HCPs	Students
Question 1	0	0
Significant difference	N/A	
Question 2	12.5	0
Significant difference	N/A	
Question 3	0	0
Significant difference	N/A	
Question 4	42.1	0
Significant difference	N/A	
Question 5	44.4	60.7
Significant difference	not significant	
Question 6	40	0
Significant difference	N/A	
Question 7	75	53.6
Significant difference	N/A	
Total	30.6	16.3
Significant difference	Significant	

As can be seen above, the data for Question 1, 2, 3, 4, 6 and 7 did not conform to the requirement of the chi-squared test. The data for question 5 was tested using the chi-squared test and showed no significant difference between the scores of the two groups. This means that a comparable number of HCPs and students chose not to commit the FTA

of asking about the Wish to Hasten Death in their questionnaire responses. A greater sample size would be required in order to verify whether there are significant differences in the percentages of the two groups who did not perform the FTA.

Nevertheless, a chi-squared test comparing the total proportion of HCP responses that did not include the FTA and the total number of student responses that did not include the FTA proved that there was a significant difference between the scores in the two group. The HCPs performed the FTA significantly less often than their student counterparts ($p < 0.001$, $\chi^2 = 11.135$). This follows the general trend of the findings of this study in that HCPs are more cautious about performing FTAs in patient encounters.

4.2 General discussion

In summary, significant differences were found in the use of T-honorics, explicit offers and requests for permission to discuss difficult topic by HCPs and students. The HCPs showed higher frequency scores for all three acts. What's more, the overall politeness scores of the two populations in their responses to question 1 and 2 showed that HCPs had significantly higher positive politeness scores than the students in both cases. What's more, there was a significant difference in the use of *asserting or presupposing knowledge of and concern for H's wants* in question 2 and the use of *questions/hedging* in question 7 with HCPs using the strategies significantly more in both cases. In addition to the use of more politeness strategies as redressive action in the above examples, HCPs were also seen to have a significantly higher rate of not performing the FTA across the whole questionnaire.

When considering all of the above results, it is most important to note the instances where there is a significant difference in the overall positive or negative politeness score. Where the overall score is not significantly different, one of the populations may employ

different strategies but their assessment of the significance of the FTA is at least superficially equivalent. Whereas, the statistics for questions 1 and 2 indicate a difference in the assessment of the FTA for H by the speakers. In this instance, the HCP population employed more positive politeness strategies than the students in question 1, indicating that they considered the FTA to be a greater threat to the patient's positive face than the students did. Likewise, in question 2, the HCPs used more positive politeness strategies than the students, showing that they considered the FTA to be more significant than the students did.

It is important to note at this stage that it is not wholly surprising that there were relatively few significant differences in the overall positive and negative politeness scores. Despite refutations of Brown and Levinson's claims of the universality of the politeness strategies in their theory, it is rarely refuted that speakers are able to recognise FTAs and adjust their speech (should they wish to) to avoid compromising the face wants of their interlocutors. Given the idea we all possess politeness strategies, it is to be expected that students are able to identify and address possible threats to the face of a patient. Slight adjustments in the use of politeness strategies over time are therefore more likely than vast discrepancies in the approach of the two groups to a given situation. Nevertheless, all of the significant differences found in the statistical analyses show that experienced HCPs employ a greater number of politeness strategies than students do.

4.3 Limitations

The data collection was carried out by means of a questionnaire, which despite practical advantages of increasing the potential sample size, saving time and increasing flexibility for all interested parties, the data obtained through questionnaires is only to a certain extent "natural" language data. The questionnaire was designed to allow participants to replicate their usual linguistic behaviour but it is likely that participants

idealise and/or summarise to a certain extent their discourse. Ideally, analysis of communicative strategies should examine natural language or ‘real’ interactions. However, given the complications of gaining access to real interactions between HCPs and patients or concerns with both patient confidentiality, possible observer effects (Labov, 1972), delays in ethical approval, collecting data from real conversations between patients and HCPs was not feasible for this study. In this sense the questionnaire provided an alternative means of gaining a broad picture of HCP-patient encounters. However, it is my hope that this paper could serve as a basis for further research into real HCP-patient encounters with future research perhaps including a fly on the wall type study or the implementation of systematic recordings of HCP-patient interactions in several centres.

Furthermore, the sampling strategy via electronic questionnaire may have resulted in a skewed data set. A limitation of this study is that the participants were neither a random sample nor a hand-picked sample, but rather the candidates determined their own participation by responding to the voluntary questionnaire they received via email. The act of responding to a voluntary questionnaire outlines character traits in the participants which are perhaps not representative of either population as a whole, such as engagement with or interest in current research. Nevertheless, we could consider that there is likely to be a comparable skew in both populations so the impact on the results here is minimal.

Despite attempts to maximise the dissemination of the questionnaire and participation in the study, the overall sample size was relatively small ($n=55$) and further reduced by inadmissible responses to Section 2 of the questionnaire. Future studies could contemplate a more systematic method carrying out face-to-face interviews with personnel in palliative care units, systematic recordings or a fly on the wall type study. This would allow for analysis of some factors which could not be included here (most notably the data for many strategies in Section 2 of the questionnaire that could not be

analysed by a chi squared tests). It would also allow for data collection from a more comparable sample from each population, in terms of gender and profession.

What's more, great natural variability between individuals in the same population due to matters or character necessitate a great sample size to ensure the populations are comparable. Thus, a greater sample size, enabling chi-squared tests for the use of each strategy for a given scenario would be crucial to reaching more definitive conclusions.

Brown and Levinson's work on politeness theory mentions prosody which can include emphasis on important words or particles and also tone of voice. This experiment did not include these aspects of language but future studies could contemplate studying patients' perceptions of FTAs according to phonological criteria, such as tone of voice and stress on given particle. Other aspects such as "dysfluency, repetitive speech, overlapping speech" examined by Steel et al. (2014) which were considered to be representative of discussing difficult or awkward topics could not be taken into account in the questionnaire data due to the use of written rather than recorded data.

Finally, it must be considered that the large quantity of statistical tests used in this study mean that there was an increased chance of finding a significant difference between two datasets. Given that we used a 5% significance level, we would expect 5% of the results to be significant by chance, even if a significant difference was not demonstrated. Hence, for every 20 tests carried out, we would expect one of them to be significant even if there was no difference between the groups.

5. Conclusions

Given the relatively small sample size available in this study, robust and generalised conclusions about the individual politeness strategies employed by HCPs are not possible at this stage. Nevertheless, the significantly higher positive politeness scores for HCPs in questions 1 and 2 of the questionnaire show that HCPs use more redressive action when performing an FTA than their student counterparts. Furthermore, the significantly lower rates of performing FTAs in HCP responses as compared with student responses reinforces the idea that HCPs are more cautious about committing FTAs. This is particularly significant given the detrimental effect that a breakdown in communication can have on the patient-HCP relationship and the subsequent negative effects on patient outcomes. It would appear that training inexperienced HCPs to be more cautious in their communications with patients could help to avoid the aforementioned breakdowns in communications.

Ideally, future research would involve comparisons between a larger and more comparable samples of students and HCPs. Politeness theory can be considered an appropriate conceptual framework for said research. A greater sample size would be necessary to enable the analysis using chi squared tests for all politeness strategies on an individual basis rather than a global negative and positive politeness score. Said sample size would have to include at least 5 individuals who did and 5 who did not employ each strategy in each population. The exact size of the necessary sample size is difficult to calculate at this stage.

It is my hope that this study could contribute to a basis upon which clear guidelines explained in terms of politeness theory rather than psychology techniques could be provided for trainee HCPs. Given the assertions that discussing difficult issues has a benefit for palliative care patients (Bolmsjö, 2000; Weir, 2012), robust training that

enables HCPs to feel confident when approaching difficult issues could encourage discussions about potentially conflictive topics and open up beneficial dialogues between patients and the healthcare teams working with them.

Future lines of research could also contemplate comparing politeness strategies in different languages, possibly providing a basis for communication training for migrant workers in the healthcare field. This is an increasingly common phenomenon in the developed world (Vujicic et al., 2004) with due to shortages of specialised personnel in some countries. Given Brown and Levinson's (1987) assumption that a main contributing factor to the assessment of an FTA is related to perceptions which can differ from one culture to another, being able to identify the politeness strategies utilised by native speakers and explain them within a clear conceptual framework could facilitate non-native speaker's adjustment to a new linguistic context in the workplace (Lindström, 2008) given the well-documented difficulties of acquired politeness norms in Second Language Acquisition (Odlin, 1989) and difficulties for non-native healthcare professionals to adapt to a new workplace's communicative conventions (Cordella & Poiani, 2014; Lindström, 2008).

It is therefore my hope that this paper may constitute a first step towards understanding how experienced healthcare professionals are able to conduct successful conversations about delicate, emotional and potentially conflictive topics, while preserving a positive relationship with the patient. What's more, the use of this knowledge in communication training could facilitate HCP-patient communication during what may be the most challenging period in the lives of patients and their families.

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7. Annexes

7.1 Questionnaire for data collection

Comunicación en Cuidados Paliativos Para cualquier duda respecto a este formulario, no dude en contactar con Rebecca Latter – rebeccadaisy.latter01@estudiant.upf.edu				
Sección 1: Información general				
¿Es usted profesional de la salud?				
Sí, soy médico/a	Sí, soy enfermero/a	Sí, soy psicólogo/a	Soy trabajador/a social	No, soy estudiante
¿Es usted estudiante?				
No, soy profesional de salud	Sí, de enfermería	Sí, de medicina	Sí, de psicología	Otro:
Género				
Hombre		Mujer		
Cuántos años/meses de experiencia tiene en cuidados paliativos en España?				
No tengo experiencia	Prácticas (indique duración)	Menos de 1 año	1-5 años	5 años o más
Interacciones con pacientes Si usted es estudiante, por favor conteste según cómo actuaría si hubiera acabado sus estudios. Si usted es profesional de la salud, por favor conteste según su práctica diaria.				
¿Cuándo se dirige a un paciente, usa el tuteo?				
Nunca	Pocas veces	Algunas veces	La mayoría de veces	Siempre
Indique a continuación qué circunstancias pueden hacer que varíe su actitud, anteriormente indicada:				
¿Cuándo se dirige a un paciente, lo hace usando sólo su nombre de pila?				
Nunca	Pocas veces	Algunas veces	La mayoría de veces	Siempre
Indique a continuación qué circunstancias pueden hacer que varíe su actitud, anteriormente indicada:				

Antes de visitar un paciente ingresado, ¿cuáles de las siguientes acciones realiza?	Nunca	Pocas veces	Algunas veces	La mayoría de veces	Siempre
Llamar a la puerta y / o pedir permiso para entrar en la habitación					
Si es la primera vez que visita al paciente, darle la mano y presentarse, indicando nombre y cargo					
Asegurarse de que la conversación transcurra en un ambiente de privacidad.					
Preguntar al paciente quién desea que esté presente durante la conversación/visita					
Hacer una pregunta abierta/genérica para iniciar la conversación					
Pedir permiso para hablar de un tema delicado o que puede generar malestar o incomodidad					
Ofrecer explícitamente la predisposición para abordar temas de interés para el paciente, cuando este lo desee					
Terminar la visita preguntando si el paciente necesita algo más.					
Despedirse explícitamente del paciente					

Sección 2 – interacciones con pacientes

Importante: Por favor, lea la siguiente situación y escriba las respuestas como si estuviera hablando con un paciente. Por ejemplo "Me gustaría hablar con usted..."

1. Usted atiende a una paciente cuyo fallecimiento prevé en pocos meses y que parece no haber hecho previsiones respecto al futuro de sus hijos (menores de edad) cuando ella no esté. Actualmente, no tiene pareja ni contacto con el padre de sus hijos. Como profesional cree que sería aconsejable que un trabajador social / experto del ámbito jurídico asesorara a la paciente. ¿Qué le diría a la paciente?

2. Está hablando con un paciente sobre su situación económica. El paciente empieza a llorar y se le ve preocupado. Sin embargo, usted cree que sería muy beneficioso para el paciente seguir con la conversación. ¿Cómo abordaría el tema?

3. Usted sabe que muchas veces a pacientes al final de la vida les ayuda hablar con algún tipo de asesor espiritual (ya sea un religioso o una persona laica). Quiere preguntar a un paciente si desearía hablar con dicho asesor. ¿Cómo se lo expondría?

4. Tiene que informar a un paciente de que su enfermedad es más grave de lo que se imaginaba. Avanza muy rápido y el pronóstico no es muy bueno. ¿Cómo se lo diría?

5. Sospecha que un paciente que atiende desea morir. Sabe que es un tema delicado pero le gustaría preguntarle para darle la oportunidad de comentar el tema. ¿Cómo se lo preguntaría?

6. Tiene un paciente que pide más tratamiento con quimioterapia. Ya lleva muchos esquemas de quimioterapia sin ningún beneficio en la progresión de la neoplasia. Tiene que explicarle que no se le administrará más quimioterapia. ¿Cómo abordaría el tema?

7. Tiene un paciente que le pide información sobre el pronóstico de su enfermedad e insiste mucho en saber cuánto tiempo le queda de vida. Sobre todo quiere saber si es probable que llegue al final del año. Usted ve que su enfermedad ha avanzado muy rápido y últimamente está mucho peor. Ve poco probable que sobreviva hasta el final del año. ¿Cómo le respondería?