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ドラマの医療現場における談話分析
── ポライトネス理論の見地よりの考察 ──

鈴　木　光　代

Discourse Analysis of Medical Interviews in Drama *ER*
── From the viewpoint of Politeness Theory ──

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While teaching students who are destined to work in the medical world, I became interested in the discourse analysis of medical interviews-between doctors/nurses and patients. I wonder how doctors and nurses could conduct medical interviews with their patients in order to make them feel at ease since the patients usually feel weak and are very sensitive in front of the medical experts. Surely doctors and nurses are medical experts and they can handle the physical problems of their patients, but they should also be more concerned with their mental aspects in order to recognize how their patients feel at the time of their medical examinations. Keeping those considerations in mind, I have studied the data collected from the American drama series *ER* and analyzed them from the viewpoint of Politeness Theory presented in *Brown & Levinson* (1987). As a result, some of the positive politeness strategies are very effective for successful communication between doctors/nurses and their patients.

Key words : Medical Interview, Discourse Analysis, Politeness Theory, Face, Positive Politeness Strategies

Introduction

When the doctor sees the patient, he/she usually asks various questions from the beginning and in the middle of the medical examination while the patient only responds those questions, which we refer to as the medical interview. In most cases, there are some characteristics typical to the medical interview, as shown below :

1) Doctors control dialogue: they use mostly closed questions which are one way questions only from the doctors and the responses from the patients are just accepted implicitly or explicitly by the doctors. As for the patients, they feel as if the doctors shift and conrol topic according to what is already set by the doctors themselves.

2) Concerning the turn-taking, unlike the usual dialogue, the doctors primarily take the initiative in carrying out their questions and assessing the parts of the patients' responses just necessary for their examinations and the patients can only take turns when offered, so that apparently the turns seem to be taken smoothly between the two sides, but actually they are controlled by the doctors in most cases.

Now let us just look at a typical example given in *Fairclough* (1992, p.139, *the way of the transcription is slightly simplified by the present writer*)[1]:

A) DOCTOR : ...And when do you get that?
PATIENT : ...Well when I eat something wrong.
DOCTOR : (*Overlapping*) How-How soon after you eat?
PATIENT : Well, ...probably an hour ...maybe less.
DOCTOR : (*Overlapping*) About an hour?
PATIENT : Maybe less ... I've cheated and I've been drinking which I shouldn't have done ....Does drinking make it worse?
DOCTOR : Ho ho uh ooh. Yes.....Especially the carbonation and the alcohol.
....Hm hm....How much do you drink?
PATIENT : ...I don't know...Enough to make me go to sleep at night ... and that's a quite a bit.
DOCTOR : One or two drinks a day?
PATIENT : Oh no no humph it's (more like) ten. ..at night.
DOCTOR : How many drinks a night.
PATIENT : At night,

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DOCTOR : ...What type of drinks?
PATIENT : Oh vodka ...yeah vodaka and ginger ale.
DOCTOR : ...How long have you been drinking that heavily?
PATIENT : ... Since I've been married.
DOCTOR : ... How long is that?
PATIENT : ... (*giggling*) Four years.

As is clearly shown in the standard medical interview like the above, the basic structure of this type of the discourse consists of three parts : a question from the doctor, a response from the patient, and an implicit or explicit acceptance of that response by the doctor. With this structure, the doctor controls the discourse topic according to his hidden agenda. On the other hand, from the standpoint of the the patient, the interview lacks in the interactive communication ; that is, the doctor seems to have authoritative figure and does not allow the patient to speak what is not included in the doctor's agenda.

When observing the above dialogue from the viewpoint of the politeness theory which I will explain later, we find the patient tries to talk his story about drinking but the doctor ignores the part that is not in his concern, which shows a kind of threatening effect on the patient. In general, the fact that doctors have authoritative figures itself does have a sort of threatening effect on the patients, and therefore, if the doctor carries out only businesslike medical interview like the above, the patient naturally feels threatened and there seems no successful interactive communication between the two. Then what should the doctors (and possibly nurses as well) do in order not to give their patients threatening impressions but to mitigate their anxious feelings and uneasiness? In order to answer this question, we would like to observe the various dialogues extracted from American famous drama series *ER* and analyze them based on the Politeness Theory given in *Brown and Levinson* (1987)[2].

Method

1. Data

For the purpose of the discourse analysis being properly exercised, the data should include not only words and expressions but also kinetic and prosodic features, and therefore collecting data from the actual medical interviews is desirable. In reality, however, the actual medical scenes involve quite sensitive personal matters which cannot easily be disclosed in any case.

As the data for this study, therefore, various medical interviews and dialogues between doctors/nurses and patients were collected from 91 stories in American Drama *ER* (from volume I to volume IV) which realistically depict what is happening at the emergency ward in the county hospital in Chicago and aslo some phrases from *Patch Adams* which picturizes the true story of the humanitarian doctor.

2. Theoretical Background

When we talk with someone, we are sort of involved in social interaction with each other. In other words, we are trying to communicate better and more effectively with people around us for the purpose of mutual understanding, as is pointed out in Gumperz (1982, p.1)[3] "communication is a social activity requiring the coordinated efforts of two or more individuals." In this social interaction, we all have our public self-image which Brown & Levinson call "face" and they formulate Politeness Theory[3]. Now let us see briefly what is asserted in their theory.

According to them, our "face" has the following two aspects which they call positive face and negative face : positive face refers to our desire to be approved of, accepted and liked by others and our need to feel that our social group shares common goals, while negative face refers to our desire not to be impeded or not to be imposed on by others. The former puts an emphasis on solidality, informality and intimacy while the latter expresses independence, formality and distance. When we are involved in certain conversations (social interactions) and we utter something (that is, we are speakers), we potentially threaten either of these two faces of our hearers; in other words, we are exercising "face threatening acts (FTA)" according to *Brown & Levinson* (1987)[4]. In such occasions, however, we generally tries to preserve our hearers' faces by using politeness strategies consciously or unconsciously, trying to decrease the weight of FTA. (Brown & Levinson formulate how to scale the weight, but I would like to leave it out in this discussion.) Politeness strategies are classified into the two in accordance with which face is being threatened : Positive Politeness and Negative Polliteness. Positive Politeness orients to preserving the positive face of other people. In this case, solidality is emphasized, so when we use positive politeness, we usually use informal pronunciation, shared dialects or slang expressions, nicknames, less indirect request and so on. On the other hand, Negative Politeness orients to preserving the negative face of othe people and the typical case is often seen where the speaker and the hearer have a social distance. When we use negative politeness, emphasizing our deference for our hearer, we usually avoid nicknames, slangs and informal pronounciation

and instead we use more indirect and impersonal expressions such as expletive-*it*.

3. How to Apply Theoretical Framework

Now let us look back to the conversations carried out in the medical situations such as held between doctors/nurses and patients in hospital. Applying the above mentioned theoretical framework to the analysis of these types of the conversations, we first need to see through the factors deciding the more successful communication which is supposed to result from the speaker's mitigating FTA's. Then, we analyze those factors and classify them in accordance with politeness strategies so that we can find out which strategies are the most influential and effective in the discourse involving docors/nurses and patients for the better communication. In other words, we should seek out what strategies the doctors/nurses should take in order to preserve their patients' faces.

Results

Through the observations of the data in the framework of Politeness Theory, we came across the fact that there is a social distance between the doctor and the patient and therefore the patient generally uses negative politeness to show their respect for the doctor. However, we found out that if the doctor uses negative politeness in the medical interview with his/her patient, the utterances sound rather impersonal, haughty and even cold on the part of his/her patient so that the latter feels left out and there can hardly be mutual understanding nor true social interaction between the two. This sort of communication is quite businesslike. It may be all right as far as the medical treatment is concerned, but what about the mental treatment of the patients? It seems like their feelings are ignored and the patient's face may be continuously threatened there. On the other hand, if the doctor/nurse use positive politeness in talking with his/her patient, the latter feels more friendly to the doctor and can talk whatever they think more freely. There is no FTA, and the better and more successful communication can be held between the two.

In short, at the medial interview or at the scene in the medical situation, positive politeness used by those engaged in the medical treatment is favorable in terms of the better communication. Here we should keep this theoretical explanation in mind; (heareafter, I use Speaker and Hearer just for the formulation) positive politeness strategies used by Speaker preserve Hearer's positive face defined as the desire to be approved of, to be liked by others and to be emphasizing the solidality & intimacy. Along with this explanation, I would like to propose some of the concrete strategies of positive politenss partly cited from *Brown and Levinson* (1987)[5] which I think are most effective. First, in order to satisfy Hearer's desire to be approved of and liked by others, Speaker claims "common ground" with Hearer, which gives the strategies as follows:

1) Speaer should take notice of Hearer's conditions (interests, wants, needs, goods).
2) Speaker can use in-group identity markers, such as address forms, dialects, and contractions.
3) Speaker can use jokes and common knowledge with Hearer

Second, emphasizing the solidality with Hearer, Speaker should convery that they are cooperators, which gives the following strategies:

4) Speaker can give offer or promise.
5) Speaker can include both himself/herself and Hearer in the same activity

There may be some other strategies, but we induced the above from the data. In any case, the principle factor controling the better conversations between the doctors/nurses and patients is to preserve the patients' positive face showing that they want to be approved of and get friendly care so that they can trust their doctors and feel assured of their medical treatment. Finally, I would like to close this section by citing the phrase by the doctor in the film *Patch Adams*:

A doctor's mission should be not just to prevent death, but also to improve the quality of life. Nurses can teach you (doctors). They've been with people every day. They wade through blood and shirt. They have a wealth of knowledge, and so do the professors you respect...I've shared the lives of patients and staff members at the hospital. I've lalughed with them. I've cried with them. That is what I want to do with my life.

Observations

Let us first observe the following medical interview with some counselling techniques, comparing it with the so-called standard medical interview A) given in Introduction:

B) PATIENT : but she really has been very unfair to me, got no
DOCTOR : hm (*overlapping*)
PATIENT : respect for me at all and I think that's one of the reasons
DOCTOR : hm (*overlapping*)
PATIENT : why I drank so much you know – and em
DOCTOR : hm... hm... hm... hm...are you (*overlapping*)

... are you back on it, have you started drinking again?

PATIENT : no

DOCTOR : oh you haven't ...

PATIENT : no ... but em one thing that the lady on the Tuesday said to me was that ... if my mother did turn me out of the house which she thinks she

DOCTOR : yes ... hum (*overlapping*)

PATIENT : may do ... because ... she doesn't like the way I've been she has turned me out before and em ... she said that

DOCTOR : hm hm (*overlapping*)

PATIENT: ... she thought that it might be possibe for me to go to a council flat

DOCTOR : right yes yeah (*overlapping*)

PATIENT : but she said she wasn't pushing it because my mother's got to sign a whole lot of things and...

DOCTOR : hm ... hm ... (*overlapping*)

PATIENT : she said it's difficult and ..there's no rush over it. I don't know whether ... I mean one thing they say in AA is that you shouldn't change anything for a year

DOCTOR : hm (*overlapping*) ... hum ... yes I think that's wise I think that's wise (5 second pause) well look I'd like to keep , you know , seeing you keep ... , you know, hearing how things are going form time to time if that's possible. *[extracted from Fairclough (1992, p.145)*[6]*, with the form of descriptions simplified by the presnt writer]*

The most striking difference between Samples A) and B) is who is taking the discourse initiative. In Sample A), topic control is exercised mainly by the doctor, while in Sample B) it is done by the patient who shifts across the discourse topics such as her mother's unfairness, her drinking and so on. In Sample B) the doctor is attentive to the patient's talk, giving proper feedback in the form of short response tokens (*"hm"*, *"right"*. *"yes"*), asking a short question which is topically related to the patient's explanation and giving some suitable suggestions. In this case, unlike in Sample A), the patient feels at ease and continue talking and exercising relevant topical development with the help of the doctor's attentive feedback. Here we find no face-threatening act by the doctor, and in fact he uses some positive politeness strategies shown in the previous section. First, we notice he gives minimum response quite timely, which means he is very interested in the patient's story ; that is, he is satisfying the patient's positive desire to be approved of. Next, in the last lines in B), we find the doctor's agreetment (*"yes I think that's wise"*), which also orients to the patient's positive face. Thirdly, the doctor implies he is offering his cooperation (*"I'd like to keep seeing you, ..hearing how things are going from time to time if that's possible."*). There may be some more strategies of preserving the patient's face such as the doctor's attitude and the tone of his voice, but the above example is cited from the written text and therefore I have not yet analyzed such kinetic and prosodic features.

Now we will see how those strategies work in the medical scenes in the film. After observing the data collected from 91 stories in *ER*, we may find those strategies work quite effectively especially in the case of the child patients and elderly ones. I cannot present all the examples here in this small paper, so I would like to show some of the most typical cases, from now on.

C) [Dr. Benton (Surgeon), Charlie (Patient, 16 years old), Dr. Ross (Pediatrician)]

Nurse : (*to Benton*) Can you see Charlie? They brought him from school.

Benton : (*to Charlie*) So what's the problem?

Charlie : My leg feels funny and my arm. I can't move it.

Benton : Have you been sick lately?

Charlie : I had the flu.

Benton : (*to Nurse*) It doesn't look surgical. I'll work him up, but find Dr. Ross.
(*to Charlie*) When did your leg get sore?

Charlie : This morning. Maybe a little last night.

Benton : You have any headaches?

Charlie : From the flu, I'm still a sort of sick.

Benton : Yeah, everybody has it. Have you fallen in the last few days?

Charlie : On Saturday. I tripped over my little brother.

Benton : They get in the way, don't they? Does your head hurt?

Charlie : No, just my arm and my back a little.

Benton : (*to Ross*) Possible left-sided hemiparesis.
(*to Charlie*) Dr. Ross is gonna take care of you. Okay?

Charlie : (*to Benton*) Thanks.
(*to Ross*) He's very nice.

Ross : Yeah. He's a prince.
(*doing medical check*) Push down like on a gas pedal. You like to drive, Charlie?

Charlie : Yeah, I just got my license.

Ross : (*testing how well Charlie's hand works*) Squeeze my hand. Harder.

Charlie : I'm trying.

Ross : Malik (*Nurse*). He is gonna take you for an MRI.

Do you know what that is?

Charlie : (*Shakes his head*)

Ross : You lie in this big tunnel which takes pictures of the inside of your head. [*ER I, Story 22*]

Let us pay attention to the phrases uttered by Dr. Benton "*Yeah, everybody has it.*" and "*They get in the way, don't they?*" which make Charlie feel approved because he feels as if Benton is on his side and supports him. In fact, Dr. Benton is a very serious doctor and rarely tells a joke but in this case there is something warm-hearted in his casual and friendly attitude. As for Dr. Ross, who is a pediatrician and is very good at dealing with children, he can easily attract his patient's interests as shown in the phrase "*You like to drive, Charlie?*" where he casually addresses the child by his first name. Incidentally, it is worthwhile mentioning here that, in *ER*, those concerned with health care almost always ask their patients their first names first of all regardless of the patients' health conditions so that they can encourage their patients in the more intimate atmosphere even in the critical situations. Let us get back to the above dialogue. Dr. Ross is also using a positive politeness strategy not to threaten the child by explaining MRI in the understandable expression. The same situation that Dr. Ross is handling a child patient by way of positive politeness strategies is shown in D):

D) Dr.Ross (Pediatrician), Child at the age of around 5 (Patient), Mother (the child's mother)

Ross : All right. Got some chocolate yogurt for the big guy with the sore clavicle.

Child : Thank you very much.

Ross : You're very welcome....You wanna see why it hurts?

Child : [Nods]

Ross : Here. Hop down.

[*Showing the X-ray film to the boy*] Do you see this line right here? Come here.

Take a look. See that? You know what that is? That is your first broken bone. You're officially a man.

Mother : I let him talk me out of bringing him last night. He said it didn't hurt.

Ross : He's such a tough guy.

Mother : He didn't wanna get in trouble. He isn't supposed to play outside after dark.

Ross : It's tough to stay in when it's this warm ...

Child : My mom says I'll get hurt.

Ross : She does? What does your dad say?

Child : I'm a klutz.

Ross : [*laughing*] He does?

Mother : He gets a lot of bumps and scrapes. His father's quite an athelete, you know?

Ross : [*to Child*] Do you fall down a lot?

Mother : Yeah. I'm not supposed to let him around without watching.

Ross : [*Trying to examine his eyes*] Let's play game. I'll cover my eye. You do the same ....

[*ER III, Story 20*]

Before examining his child patient, Dr. Ross gives him a yogurt. Giving a gift to the hearer is filling the hearer's want and is actually one of the positive politeness strategies. Furthermore, to preserve the child's face, he pretends to approve the child as a man not as a mere child : "*for the big guy*", "*You're officially a man*".) In the latter half of this conversation, Dr. Ross is apparently on the side of the child and not of his mother, supporting him as a sort of cooperator. "*He's such a tough guy.*" "*It's tough to stay in when it's this warm ...*" The echo questions like "*She does?*" and "*He does?*" function as back-channels, showing that Dr Ross is attentively listening to the child's story. Finally, in order to examine the child's eyes, Dr Ross does not use imperative expressions but instead begins with "let's" in "*Let's play game.*" There is what we call 'inclusive *we*' and using this type of "*we*" (in this case, "*us*") means the speaker and the hearer are involved in the same activity, which is definitely a positive politeness strategy. The same use of "inclusive *we*" can be found and also the very intimate address from "*buddy*" is used in the following dialogue, where a female doctor (Dr. Corday) admires Dr Ross' techinique with dealing with children.

E) Ross : [*to the child patient at the age around 4, just before lowering the upper side of the bed*]

Ok, buddy? Now we're gonna fix you up but the first thing we gotta do is stand you on your head. A kind of weird, huh?

Corday : I like your techinique.

Ross : [*to the female doctor*] Cranking the bed?

Corday : No. With children. You're so at ease with them.

Ross : It's where I spend all my time.

[ER IV, Story 3]

In the dialogue besides the one between the doctor and the patient, the similar positive politeness strategies are found, as shown below :

F) [*Jeanie* (*the physician's assistant*), *Scot*(*Patient at the age*

around 10)]

Jeanie is trying to persuade Scot to have an operation.

Jeanie : Hey, I want to talk to you about this surgery.

Scot : Dad talked all that noise.

Jeanie :I know.

I want to talk to you about it, too. The tumor you had last year is back. And they need to operate to remove it.

Scot : I'm not having any more operations.

Jeanie : I know you're scared.

Scot : I'm not scared. Just sick of all their crap, "This is the last one, Scotty." "Got it all, Scotty."

Jeanie : Yeah. Hey, if you don't have this surgery, you're gonna die.

Scot : Good. I'd rather die.

Jeanie : OK. I'll have to find someone else to share my Blackhawks/Islanders tickets with, then.

Scot : Nice try. Like you're a hockey fan.

Jeanie: Girls can't like bone-crushing, high sticking action?

Scot : Okay. Who's Tony Esposito?

Jeanie : Blackhawks' goalie. Vezina Trophy winner '70 and '72.

Scot : Not bad.

Jeanie : What do you care? You're fixing to die...?

Scot : So you really got those tickets?

Jeanie : (*smiles*) [*ER IV, Story 12*]

In the above dialogue, Jeanie is trying to persuade the child to have an operation, but he has been suffering from his illness so long that he hates further medical treatments. Jeanie understands how Scot feels about his dad (who is acutally a doctor in the same hospital) and also how hateful feelings he has towards the surgical treatment. Accordingly, Jeanie first shows proper acceptance of his remarks, saying "*I know*" and "*Yeah*", which is also one of the positive politeness strategies to give the hearer a sort of support as a cooperator. Furthermore, Jeanie tries to attract Scot's attention by mentioning famous Hockey teams' game, but he is so smart that he soon realizes her intention. Jeanie, however, has substantial knowledge about Hockey as a fan and impresses Scot by giving the correct answer to his question. Here, we find Jeanie is trying to use in-group membership technique and she actually succeeds in her attempt. Finally, Scot asks her, "*So you really got those tickets?*", which means he would like to go and see the game, implying he is going to have an operation before that. In this scene, too, we find the persuasion by the assistant physician ends successuflly, and that is because the positive politeness strategies are properly and effectively used.

There are of course unsuccessful communications happening between doctors/nurses and patients because the patients are sometimes very selfish. Let us see how such a case is handled by the senior staff.

G) *Susan* (*a young doctor*), *Mrs Garvery* (*a selfish patient in 60's*), *Kerry* (*a senior doctor*)

Susan : Mrs Garvey!

Garvey : You've got some nerve!

Susan : Mrs Garvey.

Garvey : (*reading her chart written by Susan*) Patient is uncooperative, demanding, prone to exaggerate symptoms?

Susan : Can I have my chart back?

Garvey : Give me a pen. I want this changed. Doctor's unprofessional, openly hostile.

Susan : Mrs Garvey! Your enzymes suggest a heart attack. We need to do an echocardiogram.

Garvey : What's that?

Susan : It's like an ultrasound of your heart.

Garvey : Why do I need one of these?

Susan : (*getting irritated*) We need to make sure that your artery isn't blocked.

Garvey : I don't understand. Explain it again.

Then Susan hysterically explains by drawing an awful picture of the heart, which really threatens Mrs Garvey.

Later Kerry explains Mrs Garvery how to treat her illness in the very calm atmosphere, gently touching her hand. Mrs Garvey feels so relaxed and attentively listens to what Kerry says. Seeing this, Susan is shocked and is blamed for being so hard on Mrs Garvey. Finally Kerry advises Susan.

Kerry : One of the nurses alerted me that Ethel was about to sign out AMA (*against medical advice*), which in her condition might have killed her. I thought it better to indulge her in order to save her life.

Susan : Good thinking.

Kerry : I know it's frustrating dealing with difficult patients. But you have a tendency to become anger-locked and inflexible.

Susan : Thank you for pointing that out.

Kerry : If you feel yourself getting dug in, just call me. I'm here to help. [*ER II, Story 19*]

Certainly it is very important for the medical staff such as

doctors and nurses to give prompt and proper medical treatment to their patients, but it is also necessary to make their patients feel at ease especially in the case of emergency; patients really want to feel secured all the because they are afraid of being in serious physical conditions or in danger of death. Accordingly, the more appropriate use of language and attitude towards the patients will be essential, not to speak of the best possible medical treatments. For that purpose, let us hope that the positive politeness strategies given in this paper will be favorably made the best use of. Finally, I would like to further investigate these kinds of strategies and effectively incooperate them in English education.

REFERENCES

1) Fairclough, N.: *Discourse and Social Change*, 137-168, 1992, Polity Press, UK.
2) Brown, P., Levionson. S.C.: *Politeness*, 1987, Cambridge University Press.
3) Gumperz, J. J.: *Discourse Strategies*, 1982, Cambridge University Press.
4) *See* 2) *above.*
5) *See* 2) *above.*
6) *See* 1) *above.*

SOURCES OF DATA

ER I (Story 1—Story 25), Warner Home Video, 1995.
ER II (Story 1—Story 22), Warner Home Video, 1995.
ER III (Story 1—Story 22), Warner Home Video, 1995.
ER IV (Story 1—Story 22), Warner Home Video, 1997-8.
Patch Adams, Universal Studios, 2004.

要　　　旨

本研究では，医療の現場における医療関係者(特に医師や看護婦)と患者とのあいだの談話を分析することによって，医療関係者が「医をもって尽くす」とともに，「言葉をもって尽くす」にはどのような談話運用をしたらよいのかを考察しようと試みた。その際，医療を志す学生たちの英語学習においてどのような英語運用が役立つだろうということをも念頭にしながら試みたので，実際には，海外ドラマシリーズERよりの会話を収集し分析をした。分析には，Brown & Levinson (1987)で提唱されたポライトネス理論を適用させ，どういったストラテジーを用いると，よりよいコミュニケーションを成立させることができるかに焦点をあててみた。その結果，特にPositive Politeness Strategiesの効果を見ることができた。