Introduction

This book is concerned with the linguistic analysis of face-to-face clinical interactions between physicians and older adults in the context of medical consultations. This is a fieldwork-driven study, reporting empirical evidence in a previously under-researched context, in which physicians visit patients and provide in-home medical consultations with family members, in conjunction with other members of a healthcare team. All the patient–doctor exchanges reported here were collected from the professional practice in authentic settings, and the transcribed data are supplemented by one-to-one interviews with the physician participants and field notes.

Western concepts, terms such as patient/person-centred care and communication, have been disseminated worldwide and are now being embedded into real-life practice in health and social care. Previous studies investigating patient-centred communication have included a wide range of situations across the specialities, and different contexts may influence communication behaviours between patient and professionals. Existing studies on interactions between patients and healthcare providers reveal that both are important co-players in consultations and that managing this dynamic has become increasingly important to a higher quality of care of global ageing populations. The current healthcare debates involving the Covid-19 pandemic have articulated a vast range of critical reflections on effective communication in primary care, treatment and therapy, emergency care, administrative responses, and professionals' empathy and unempathic responses in the communication (Barello & Graffigna, 2020; Finset *et al*., 2020; Holt, 2020; Houchens & Tipirneni, 2020; Musolff *et al*., 2022). This book aims to contribute to provide: (1) a better understanding of how expressions of patients and professionals are shaped and developed, and how it could characterise the attributes of patient-centred communication; and (2) cross-cultural considerations in clinical encounters and the sociocultural differences between the UK, US, Japan and other societies in which patient-centred communication models are employed.

Regarding the terminology on patient-centred communication, while many studies use 'patient-centred care', 'person-centred care', 'people-centred care' or 'PCC' interchangeably, I use only the term 'PCC' for 'patient-centred communication' throughout this book. In addition, this

differentiates between the study of patient-centred care and the study of patient-centred communication and assumes that the former includes the latter.

I.1 Scope of the Book

Chapter 1 outlines the existing conceptualisation of patient/person-centred care, with particular reference to patient-centred communication (PCC). It starts with the original concept of patient-centredness in the UK and US. The operational definition of PCC proposed by Epstein *et al.* (2005) is then discussed, followed by a review of the consultation model, Calgary-Cambridge Guide (Silverman *et al.*, 2013) and approaches to applied linguistics in healthcare settings. I then review cultural differences of the conceptualisations and applications of PCC.

Chapter 2 presents the key concepts of face and linguistic politeness and explores the discussions surrounding the classical notions of face and politeness in healthcare studies. This includes a clarification of Brown and Levinson's (1987) concepts of positive face and negative face, a discussion of social and contextual variability in linguistic behaviours, a review of the critiques of Brown and Levinson's theory and an overview of discursive approaches to politeness proposed by Locher and Watts (2005). I also take into consideration the theories of 'individualism versus collectivism' by Hofstede *et al.* ([1991] 2010) and 'high-/low-context' by Hall (1976), and the issue of cultural variability. I then turn to empirical investigations of face and politeness in medical encounters, and I suggest that Brown and Levinson's concept of face is appropriate to re-conceptualise PCC verbal dimensions for the development of the analytical categories in this study.

Chapter 3 describes the fieldwork and data and the development of the analytical framework. Since the data are based on the observational fieldwork and audio recordings of physician in-home medical consultations, I detail the methods for data collection, explaining the methodological position taken in the study, and then describe the data sample. The analysis is rooted in pragmatics and considers PCC-relevant communicative acts with reference to terminologies and definitions from the Calgary-Cambridge Guide (Silverman *et al.*, 2013) and Brown and Levinson's (1987) conceptualisations of face and politeness strategies. By drawing on both medical and linguistics concepts, the analysis advances the understanding of cultural diversity in healthcare interactions. I present a full illustration of the framework, the Face-PCC analytical categories. Short extracts from the corpus are used for illustrative purposes.

Chapter 4 explores the first PCC dimension at the beginning of the consultations, physician questioning and listening techniques in the medical consultations. This involves delivering 'Initial general remarks', 'Gradually moves from open to closed questions' and 'Repetition, paraphrasing and interpretation'. I also discuss potential non-PCC aspects

(which refers to opposite examples that potentially fail to accomplish PCC), such as 'Sequence of closed questions at the beginning' and 'Interruption'. From this chapter onwards, Face-PCC elements emerging from one-to-one interviews with physician participants and longer extracts from the transcripts of the consultations are brought into the narrative interpretation of the linguistic material, to clarify some of the interpretations and further contextualise the doctors' PCC.

Chapter 5 discusses prominent features of empathy and acceptance; that is, doctors' acknowledgement of patients' concerns, fears, feelings and thoughts. I discuss the concept of clinical empathy and its background, including recent studies. Key aspects include 'Understanding and appreciation of the patient's feelings', 'Expressions of positive regard' and 'Silence as empathic anticipation'. For a potential non-PCC aspect, I discuss 'Being judgemental'.

Chapter 6 addresses physicians' attempts to understand the patient's problems and encourage shared decision-making, rather than providing one-way information. Patients' involvement was viewed as the key consultation skills in the data, suggesting that the actual use of PCC in a decision-making process can vary considerably depending on the culture. The data involved a high degree of negative politeness strategies rather than positive politeness strategies in the consultations. The key aspects include 'Sharing understanding', 'Sharing thinking' and 'Offering suggestions'. For a potential non-PCC aspect, I discuss 'No shared discussion'.

Chapter 7 concerns that physicians' responses that leave space for patients and show respect for their freedom minimise the imposition on the patient. This aspect was particularly noticeable in the in-home medical consultations: one particular cultural aspect is related to 'physical touch' and 'proximity – closeness/distance'. Key aspects involve 'Open questions that occur throughout the session', 'Checking for understanding' and 'Linguistic deference'. For potential non-PCC aspects, I discuss 'Directives' and 'Touching without asking'.

Finally, Chapter 8 deals with considerations of cultural diversity within PCC and the Western-originated model of patient/person-centredness in different cultures. It also includes difficulties encountered when conducting fieldwork, recommendations and transferring the knowledge to future professional training.