Affiliative Strategies to Manage Rapport in Spanish and British Medical Consultations

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ABSTRACT
The present study is framed within the Rapport Management (Spencer-Oatey, 2000, 2008) and Sociopragmatic Interactional Principles theories (Spencer-Oatey and Jiang, 2003) to examine the strategies developed in medical consultations in Spain and England which enhance doctor-patient relationships. One of the strategies that appeared in the data analysed showed that there are affiliative strategies to display closeness with the listener, although the type of strategy and the way to deal with closeness-distance greatly varies between these two socio-cultural settings. It is so because there are different communicative styles based on Sociopragmatic Interactional Principles rooted in every culture depending on specific considerations of face, rights and obligations and interactional goals in the mind of interlocutors. There may be various motivations to find this: the existing power asymmetry between interlocutors together with different cultural assumptions about the rights and obligations they assume in medical consultations will consequently imply a different way of managing relations, and therefore affiliative strategies may be constrained by this worldview.The present study will then explore the existing interconnection between the culturally biased concepts of power and rights and obligations, on the one hand, and pragmatic affiliative strategies, on the other, as a result of those conceptualizations.

Key words: Sociopragmatic interactional principles, rapport, power, rights and obligations, affiliative strategies.

Estrategias afiliativas para la gestión de relaciones interpersonales en consultas médicas españolas y británicas

RESUMEN
El presente estudio se enmarca en la teoría de Gestión de Relaciones Interpersonales (Spencer-Oatey, 2000, 2008) y los Principios Sociopragmáticos de Interacción (Spencer-Oatey y Jiang, 2003) para examinar las estrategias desarrolladas en consultas médicas españolas y británicas y que refuerzan la relación médico-paciente. Una de las estrategias que se observó en los datos analizados demuestra que hay una serie de estrategias afiliativas para mostrar cercanía con el oyente, aunque el tipo de estrategia y el modo de manifestar cercanía-lejanía varía sustancialmente en ambos contextos socio-culturales. Esto se debe a que hay diferentes estilos comunicativos basados en principios sociopragmáticos de la interacción establecidos en cada cultura dependiendo de consideraciones de imagen, derechos y obligaciones y objetivos interaccionales existentes en la mente de los interlocutores. Puede haber distintas motivaciones para esto: la asimetría de poder existente entre los interlocutores junto con la variación en cuanto a supuestos culturales sobre derechos y obligaciones que se asumen en la consulta médica implicará variación en cuanto a la forma de gestionar relaciones.

El presente estudio, por tanto, explora la interconexión existente entre los conceptos de poder y derechos y obligaciones culturalmente orientados, por un lado, y estrategias afiliativas pragmáticas, por el otro, como resultado de esas conceptualizaciones.

Palabras clave: Principios sociopragmáticos de la interacción, relaciones interpersonales, poder, derechos y obligaciones, estrategias afiliativas.

1. INTRODUCTION

This study shows that institutionalized situations such as those given in medical consultations are not only based on transactional aspects. Rather, interlocutors combine in their communicative activity both transactional and interactional strategies; whereas the former are necessary to fulfill each participant's interests, the latter will constitute, among others, rapport building activities[1] in order to achieve their goals. Nonetheless, even though transaction and interaction are like a two-sided coin in interaction, it is expected that one aspect may take precedence over the other (Coupland *et al.*, 1992; Coupland, 2000; Spencer-Oatey, 2008). Since it has been demonstrated that the communication developed within the context at stake is highly negotiated between doctor and patient and that there is a difference in terms of power (Cordella, 1999) between interlocutors, it is expected to find a need to maintain positive rapport (i.e. maintenance or enhancement of the relationship between interlocutors) to achieve at least one common goal: solve a health problem. Nonetheless, which goals are relevant for interlocutors in interaction is something that must be addressed after analyzing their attitudes as shown in the data, rather than taking them for granted.

But, how do interlocutors maintain or enhance rapport?, In fact, the way to achieve this may vary from culture to culture. It is so because, needless to say, the way we communicate and interpret others highly depend on cultural values transferred to communication in an automatic and unconscious way, as reflected in anthropological and cultural studies (Hofstede, 1994, 2001, 2004, 2007). This study, then, attempts to focus on those culturally-biased aspects in communication that may reflect variation in interaction. In other words, besides particular goals in interaction, there are different orientations that can be chosen and negotiated throughout interaction: rapport enhancement orientation, rapport maintenance orientation, rapport neglect orientation and rapport challenge orientation (Spencer-

[1] This term has been previously used by Placencia (2004). Even though the framework is different from Spencer-Oatey (2000), it still reflects the fact that interlocutors make use of particular strategies to maintain or improve the relationship between them

Oatey, 2008: 28). Even though they may be seen as a parallel account to Brown and Levinson's (1978, 1987) framework of politeness, in which different strategies are to be applied in terms of the estimation of risk of face loss, Rapport Management (RM, henceforth) is radically different in the sense that we are not talking about risk taking but about the decisions made by the participants due to situational and individual reasons. Moreover, RM does not assume that all interactional activity is motivated by the face of the participants, but by a multiplicity of factors that influence interaction, so that face is a key motivation, but not the only one. Because of the common interests of both doctor and patient, the medical consultation would be expected to correspond to a rapport maintenance or enhancement orientation, mainly because patients will need the cooperation of the doctor in order to treat a typically sensitive topic for them, whilst doctors will need the patients' cooperation in order to develop their job successfully.

In particular, the object under study is those strategies developed by both doctor and patient in order to show empathy, closeness or respect or, in other words, those strategies directly related to the need of affiliation with the other interlocutor, as they are expected to be indicative of rapport maintenance or enhancement in this context. There are studies that show specific features related to the doctor's profile (Cordella, 2003), at the same time that patients seem to have many others (Cordella, 2004). However, this paper will show that it is the study of communication considering both interlocutors that will give a richer account on how interaction is dynamically constituted and developed. By considering both doctor and patient production and reactions, this study aims at enabling a deeper understanding of communication and rapport-building strategies. It is so because meaning is constantly negotiated, and considering only one of the interlocutors may be misleading or may fall short in presenting a comprehensive panorama of how communication is achieved (Arundale, 2006). It is, then, the constant negotiation of meaning *in situ* that causes both speaker and hearer adopting particular interpersonal attitudes.

Also, this study is built under the assumption that rapport is not an individualistic aspect of communication; instead, it refers to how interpersonal relations are interactionally achieved and automatically negotiated, considering not only the traditional aspects of face, but also others such as the rights and obligations interlocutors adopt once they are engaged in interaction (Fraser, 1990; Spencer-Oatey, 2000, 2008). In other words, this study will follow the current trend to view politeness and, more generally speaking, the management of rapport, as something which is interactionally achieved, and not an individualistic aspect of communication, as will be explained in section 2. This shift from a purely social perspective to an interactional viewpoint also means blurring the boundaries between social, cognitive and socio-psychological aspects of communication to give way to an integrated framework where concepts and theories are the consequence of the interaction itself, and not the other way round. In this sense, examining the data will help understand not only the similarities and differences

among both settings but also whether RM is applicable to linguistic data. Previous empirical research on RM have been developed mainly based on questionnaires (Spencer-Oatey, 2005) or illustrative examples (Campbell, 2005).

On the other hand, there is stylistic variation between cultures caused by those underlying communicative principles called Sociopragmatic Interactional Principles (SIPs, henceforth) (Spencer-Oatey and Jiang, 2003; Hernández-López y Placencia, 2004; Spencer-Oatey, 2008). Nonetheless, these are in need of closer scrutiny, as they are not a closed list of dichotomies but dynamic aspects of language which may appear in different degrees depending on the situation, culture and individual characteristics. For this reason, the SIPs existing in Spanish and English medical encounters need to be further examined in order to gain a deep understanding of those cross-cultural differences that may produce misunderstandings (House *et al.,* 2003), pragmatic failure (Thomas, 1983) or culture clashes in particular situations. In this sense, by going to sociopragmatic aspects of communication (SIPS) to psico-social aspects (in this case, rights and obligations), it is the aim of this paper to gain a wider view of communication at different levels.

It is worth remembering that SIPs are not arbitrary aspects of communication; instead, they underlie cultural assumptions that interlocutors unconsciously bear in mind. Apart from demographic and sociological aspects such as age, gender, status, power or distance, SIPs also show culturally biased aspects of language such as face, rights and obligations and interactional goals. In other words, recent research (Spencer-Oatey, 2000, 2008) has shown that it is not only face the aspect of communication that makes interlocutors communicate in a certain way, but also the conceptualization of those communicative rights and obligations that each individual expects to maintain in the interaction with others. Also, the achievement of goals is something that can be interactionally negotiated and, consequently, may present variation across cultures. What this study will come to demonstrate, then, is the fact that SIPs do not work arbitrarily, but they operate depending on deeper and more abstract concepts of power asymmetry and rights and obligations, the latter being an under-explored factor in latest research.

2. MOVING FROM POLITENESS THEORY TO RAPPORT MANAGEMENT

Since the appearance of Brown and Levinson's (1978, 1987) Politeness Theory and Sperber and Wilson's (1986, 1995) Relevance Theory, and during more than two decades, pragmatic studies have been characterized by being chiefly social or cognitive, as if communication could be divided into bits to explain interactional phenomena in isolation. The last decade, in turn, meant the emergence of a more comprehensive, integrated perspective of communication where its complexity is

acknowledged and the frontiers between perspectives are blurred. It is in this context that new perspectives to politeness and in particular RM appeared.

Seminal works on politeness such as Brown and Levinson's (1978, 1987), Lakoff's (1973), Leech's (1983) and Fraser's (1990) represented the initial stage in which how we communicate started to be relevant in linguistics, besides what we communicate. It also involved considering social and cultural factors as key elements influencing language and interaction in general. However, the debate arisen around Politeness Theory (Brown and Levinson, 1978) and face as its core and only dimension influencing the way individuals interact also brought about a series of weaknesses, which were in need of further examination: namely, the universality, ethnocentrism and individualism existing in Politeness Theory (Ide, 1989; Matsumoto, 1989; Kasper, 1990 and Gu, 1990, among others), the delimitation of politeness to a clear-cut dichotomy, positive and negative politeness (Hickey, 1991; Garcés, 1991; Fant, 1989, 1995; Bravo, 1999; Spencer-Oatey, 2000; Tracy, 1990, among others), the neglect of equal relevance to positive politeness (Bravo, 2001), the constraint of politeness to three contextual variables working together in a formulaic fashion, neglecting other factors such as affect (Garcés, 1991, 1993), the under-explanation of impoliteness (Culpeper, 1996, Culpeper *et al.,* 2003) and self-politeness (Chen, 2001), the wrong conception that politeness is attached to certain linguistic structures, the lack of consensus when defining politeness (Pizziconi, 2003), etc. These are just a few contributions that had motivated a shift of perspective, from a purely social perspective to the study of interactional pragmatics, whose perspective very much relates to RM.

Within what is called Interactional Pragmatics (Arundale, 2006), a discursive view to politeness appeared as an alternative account to the traditional theoretical politeness and in a parallel fashion to RM. The motivation for this change of perspective lies on the previously explained weaknesses of politeness, on the one hand, and the several attempts to prevent an interpretation of communication from a monolithic perspective, namely cognitive theories (Sperber and Wilson, 1986), cultural and anthropological (Hofstede, 1994, 2001, 2007) or contrastive studies (Blum-Kulka *et al.*, 1989). In other words, the management of interpersonal relations does not have to be explained from a unique area of research, nor should it be tied to a central concept (eg., *face*): the management of interpersonal relations will in turn need a more comprehensive conceptual framework where interpretative, social, cognitive, cultural, situational and individual factors should be integrated to complement each other and explain why and how communication is culturally developed in diverging ways. This perspective rejects predicting a theory *a priori* and involves a *post facto* description of reality in communication (Haugh, 2007), in which the perceptions of the interlocutors are needed to avoid scientific bias and meaning is considered to be dynamically (de)constructed and negotiated. Even though the latest theories on interpersonal communication considerably vary from one another, the common ground they share is precisely the above mentioned features of communication as a whole.

The main reason why the present study is based on RM is twofold: first, and as explained before, there is a need to consider a wide perspective of communication in which a variety of elements are integrated together and therefore to categorize reality in terms of not only pragmalinguistic descriptions but also sociopragmatic perceptions of reality (in this case, SIPs) in relation to psico-social aspects (rights and obligations); and second, even though the approach of the latest theories have considerably changed from the original work of Brown and Levinson (1978, 1987), they are still focused on the discussion on *face*, instead of attempting to integrate all those elements that explain communication from a multilayered, socio-psychological perspective. Rapport management is, in fact, a theory where *face* is one element or, better said, one of the three bases of rapport, being *sociality rights/obligations* and *interactional goals* the other two. As Spencer-Oatey explains, rapport, which can be enhanced, maintained, challenged or neglected, is based on three main considerations interlocutors implicitly hold in their minds:

> Face management […] involves the management of face sensitivities and, following Goffman (1967: 5), I define face as 'the positive social value a person effectively claims for himself [*sic*] by the line others assume he has taken during a particular contact' […]. The management of sociality rights and obligations, on the other hand, involves the management of social expectancies, which I define as 'fundamental social entitlements that a person effectively claims for him/herself in his/her interactions with others'. In other words, face is associated with personal/relational/social value, and is concerned with people's sense of worth, dignity, honour, reputation, competence and so on. Sociality rights and obligations, on the other hand, are concerned with social expectancies, and reflect people's concerns over fairness, consideration, and behavioural appropriateness. Interactional goals refer to the specific task and/or relational goals that people may have when they interact with each other (Spencer-Oatey, 2008: 11).

In relation to this, Spencer-Oatey (2008) and Spencer-Oatey and Jiang (2003) believe that people have cultural and situational beliefs about the principles that should constrain interaction. This is what they call Sociopragmatic Interactional Principles (SIPs), a re-conceptualization of Leech's (1983) pragmatic maxims and Kim's (1994) conversational constraints. SIPs are, in fact,

> Socioculturally-based principles, scalar in nature, that guide or influence people's productive and interpretive use of language [...] We maintain that SIPs help manage (and hence are not alternatives to) people's face/rapport management concerns. People's face needs and interactional rights and obligations need to be appropriately balanced relative to their task needs, and so societies develop norms and preferences for achieving thi (Spencer-Oatey and Jiang, 2003: 1635)

Even though these are sociopragmatic aspects of language that have been explored under varying terms (e. g., *dimensions of cross-cultural difference* (House 2000) or *cultural priorities* (Fant, 1989)), it is also true that more research

explaining SIPs in relation to cultural and situational values and within a framework with a wider scope are needed. Also, it is still a necessity to understand how the three bases of rapport previously explained are socio-psychological values that guide linguistic behaviour and thus influence the way SIPs are performed to achieve the desired orientation in rapport (maintaining, enhancing, challenging or neglecting rapport).

As a preliminary study to the present paper, Hernandez Lopez and Placencia (2004) focused on British and Spanish interactions to conclude that there is a series of SIPs that clearly influence communication, at the same time that these are biased by the different conceptualizations of face, rights and obligations and task achievement. The different SIPs found in British and Spanish interactions where:

DIMENSIONS OF CROSS-CULTURAL *DIFFERENCES*	**Spanish**		**British English**
	Directness	----------	Indirectness
	Closeness	----------	Respectful distance
	Novelty	----------	Routinisation
	Self-affirmation	----------	Consensus
	Group Orientation	----------	Individuality

Figure 1. Adapted from Hernández-López y Placencia (2004: 147)[2]

Also, Hernández-López and Placencia (2004) explained how SIPs, the linguistic expression of what is held as appropriate or not in every situation, are value-laden principles which are motivated by different conceptualizations of face, rights and obligations and task achievement. Thus, face is conceptualized differently in the Spanish and British societies in the sense that there is an orientation towards the addressee in the latter (cf. House, 2000), and therefore there is a need to find consensus with the hearer, keep distance and being indirect, whereas face in the Spanish society is understood as a way of showing camaraderie and spontaneity, which are two positively oriented features of social life between Spaniards. In terms of rights and obligations, there are certain expectations that interlocutors hold

[2] The terminology used and descriptions of what these dichotomies refer to have been adapted from the existing literature on cross-cultural studies: namely, directness-indirectness (Blum-Kulka, 1989), closeness-respectful distance (Márquez Reiter and Placencia, 2004), routinisation-novelty (Traverso, 2001), consensus-self affirmation (Fant, 1989; Bravo, 1999; Hernández Flores, 2004), group orientation-individuality (Gu, 1990; Mao, 1994; Matsumoto, 1988).

and involve modifications in their way of communicating and interpreting messages. For instance, Spanish requests appeared to be much more direct than English requests in most of the cases. However, when the request referred to something beyond the role assumed by interlocutors, Spanish speakers preferred to modify their request and perform it in a more indirect way. These are, then, instances of how language is unconsciously modified in terms of socio-psychological values that interlocutors hold in interaction.

Nonetheless, how rights and obligations influence communication is something that has been under-explored so far. Moreover, SIPs are understood as gradual dichotomies that, even when they reflect interactional reality, may create the misconception that British interactions are distant as such whereas Spanish interactions are direct and friendly. For this reason, this study attempts to explore the strategies used in English and Spanish to show closeness to the addressee and how they are performed differently. A discussion on how rights and obligations (a psico-social dimension) influence the affiliative strategies used in interaction (sociopragmatic and pragmalinguistic dimension) will be provided to understand communication as a multilayered, value-laden framework. In order to do this, this study will consider the most salient affiliative strategies in each corpus to underpin what they say about the rights and obligations participants hold as appropriate. In this sense, this study will reveal whether RM may be applied to real data.

3. INTERPERSONAL COMMUNICATION IN MEDICAL CONSULTATIONS

Some years ago, Candlin and Candlin (2003: 135) affirmed that even though studies on medical consultations are quite prolific, they do not show a sense of evolution among themselves, as their thematic nature and purpose dramatically vary from one to another. They usually fall short in explaining how interpersonal communication is developed in medical contexts. Other authors hightlighted the importance of linguistic studies (rather than medical research itself) to help improve communication in professional settings (Davies, 2003, Iedema, 2005). From that time one, this field of study has witnessed a rapid growth in Anglosaxon contexts, with even specialized journals such as *Communication and Medicine.* In contrast, it is worth noting how scarce these studies are in the Hispanic world, although a few main exponents may be found (Cordella, 1999, 2003, 2004, 2007; Cepeda, 2005, 2006; Garayzabal, 2006). Works such as those of Cordella (1999, 2003, 2004) clarify to a great extent the type of interaction that is developed between doctors and patients, whereas other studies have been focused on specific linguistic, sociological or pragmatic features (Bissel *et al.* 2004*,* Lehtinen, 2007, Young and Flower, 2002). This study, in turn, will focus on those strategies shown in two cultures which are necessary to negotiate or compensate for differences in status, role, knowledge, personal situation and so on: affiliative strategies. Despite

the published research taking these into account (Cordella, 2000; Cepeda 2006), the main novelty respect to previous ones is, first, the comparative nature of this study, and second, the application of some dimensions of RM to real data. This is an actual necessity within medical health care communication research, rather than a experimental activity, as supported by the latest developments of politeness in medical contexts (Backhaus, 2009; Brown and Crawford, 2009; Zayts and Kang, 2009; Graham, 2009; Harrison and Barlow, 2009). These all show the need to apply updated frameworks of politeness such as those of Watts (2003, 2005) and Mills (2003). Only Campbell (2005) has attempted to apply RM to medical encounters.

Campbell (2005) supports the idea that "the most effective physicians are those who fulfil not only the roles of discoverer of pathology and healer (i.e., instrumental behaviours) but also of psychosocial caregiver (i.e., affective behaviours)" (424). Considering that physicians and patients may deal with emotionally charged interaction, cooperation and positive talk may be more obvious that in other professional contexts where personal issues are not at stake (Roter and Hall, 1992). In this sense both parties in interaction are expected to develop particular strategies to avoid negative or problematic rapport (Campbell, 2005: 431). This is of special interest not only from a linguistic perspective, but also for medical research, as it is proven that when physicians listen fully and engage in interpersonal communication, the patient's psychological status and physiological symptoms may improve considerably (Stewart, 2003).

With very few exceptions (Lehtinen, 2007), most studies examining doctor-patient interactions focus on either the talk that doctors perform (Cordella 2000, 2002, 2003), the patients' discourse or both, though analysed separately (Cordella, 2004). This paper will focus on the most salient affiliative features in each contexts, regardless who initiates them and whether they are equivalent or not in other contexts. By doing so, there will be a clearer panorama of what constitutes the main strategy both to develop positive rapport and to know how it relates to the rights and obligation dimension.

4. METHODOLOGY

The data consist of 20 naturally-occurring audio-recorded interactions between doctor and patient, in England and Spain. The interactions were randomly chosen out of a set of 120 English interactions and 60 Spanish interactions.

The method for data collection varied from one corpus to another. In the Spanish case, the recordings were made with a minidisk recorder and a microphone attached to it, after obtaining official permission in two different healthcare centers in Huelva and Madrid. Patients had been previously informed of the situation, and only those who agreed in being recorded in subsequent visits were considered to be included in this study. This means that the interactions used for this study correspond to follow-up sessions where doctor and patient know each other. In

terms of naturalness, the fact that the recording was known to everyone did not seem to influence the way the interactions were developed, as patients had been informed with plenty of time. This was done after obtaining permission from the medical center and the doctors to be recorded. Due to ethical reasons, the process was an arduous task, which required plenty of time and also the provision of a written report in which the purposes of the recordings were clearly stated. As with the British corpus, these interactions correspond to general practioners, as their thematic nature and relationship with patients may differ from those of specialists.

The English data were taken from the *British National Corpus (BNC)*[3], which is a collection of 100 million-word interactions collected by the academic consortium *Oxford University Press.* Some of the features of this corpus are:

1. Monolingual**:** It covers modern British English, so other languages used in Britain have been discarded.

2. Synchronic: It covers British English from the late twentieth century onwards.

3. General: It includes many different styles and varieties, and is not limited to any particular subject field, genre or register, although it has been categorised in terms of situational aspects and contextual factors. That is why it was very easy to isolate interactions occurring in medical consultations.

4. The data collected were intended to be demographically and geographically representative.

In both cases, interactions with teenagers and children were discarded, as well as first time encounters, as these factors may influence the type of interaction undertaken and other strategic reactions might be expected to occur. That is, only relationship-renewing[4] interactions were considered. Even though the British corpus is more statistically representative (it covers all regions in England) there are reasons to think that the Spanish data are significant for the purposes of this study, as there is a clear tendency to use similar affilitative strategies in most of the interactions analyzed.

It is worth noting that, even though the medical system found in England and Spain may vary, the interactions analysed share the fact that they belong to the public system in each country, and also that they were face-to-face interactions. Also, in both corpora equal numbers of women and men physicians were considered, so that affiliative strategies are not seen as influenced by gender roles.

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[3] www.natcorp.ox.ac.uk

[4] Term taken from Heritage (1984: 242), in opposition to 'relationship-shaped' interactions, or first-time encounters.

5. THE RESULTS

In line with House (2000), Spencer-Oatey and Jiang (2003) and Hernández-López y Placencia (2004), this study supports the idea that there are SIPs underlying communication which are, in turn, caused by cultural values and the conceptualization of face, rights and obligations and interactional goals. However, only face has been fully explored in the current literature, whereas rights and obligations is a factor which still needs empirical evidence. For this reason, the analysis of data will be focused on affiliative strategies as the reflection of SIPs and their relationship with the righst and obligations dimension.

After examining the data, two main affiliative strategies were found: the use of humour and small talk in the form of personal, unsolicited information[5]. However, they operate in diverging ways in both settings.

5. 1. HUMOUR AND IRONY IN MEDICAL CONSULTATIONS

The data show that humour is a frequent device utilised in British medical consultations. In fact, seven out of ten interactions showed varying forms of irony or humour in the development of the doctor-patient interaction. This has been fully explored in research, as it has been proven that humour not only has positive effects on interpersonal relationships (Graham, 1995; Hampes, 1992), but is also of effective help in therapeutic settings (Lacourt, 2005; Martin, 2001; Mizzo and Welter, 2006). Also, Mizzo and Welter (2006) provide a classification of humour, and affirm that the type found in this context is affiliative, instead of aggressive, playful or serious humour. Affiliative humour, then, is considered to be the one used to cause temporary enjoyment and reassurement with the object of diminishing tension (Ziv, 1984), reinforcing social support (Lefcourt, 2001) or providing a more positive outlook of life (Hyers, 1996). Also, Aune and Wong (2002) found that those participants involved in the use of humour may find more satisfaction in personal relationships and/or the professional setting they are engaged. What is also seen in the use of humour is that interlocutors adopt different roles that develop as a game known by both participants. In the light of this fact, the data analysed show three main types of affiliative humour: 1. description of the

[5] This study is part of a wider research project in which all the interpersonal strategies found in medical consultations have been analysed in interaction, considering whole strings of talk, and not only the turns where these features occur. The final results are gathered in the author's PhD Thesis submitted in June 2009. A variety of interpersonal features were shown to be characteristic of medical consultations, though significantly, those were very different in British and Spanish consultations. The most salient feature in British interactions was the use of humor initiated by the doctor, while the most significant aspect in Spanish interactions was the display of closeness through small talk. This study, then, is only based on the most salient interpersonal features found in both corpora.

period the patient is going through, 2. placing responsibility on the patient, and 3. changing roles. Significantly, the initiative to introduce humoristic episodes is always taken by the doctor, whereas the patient always follows up.

In interaction (1), the doctor makes an ironic comment about the period the patient is going through:

(1) British data:

D [1] Right, what can I do for you this morning?

P [2] Well erm I I'm still [laugh] I'm still having them panic attacks I've still made a diary of it .

D [3] A merry Christmas, haha.
[4] Let me have a look.

P [5] Haha, and er I've I've

D [6] Oh yeah.

As can be seen, the fact that laugh follows the ironic comment "a merry Christmas" is a clear sign of the acknowledgment of humour in this situation.

Interaction (2) shows, in turn, how the doctor places the responsibility of the health-related problem to the patient, although it is taken as clearly ironic due to the way it is managed and its response:

(2) British medical consultation.

D [1] [...] see see you in a second.
[2] Now what can we do for Jane? [...] you're you're wheezing?
[3] You're a bad woman .

P [4] [...] Dr Aye really quite bad.

D [5] [...] a lovely day like that, you're wheezing. [...]

In this case, the patient is classified as a "bad woman" because she is wheezing in a lovely day. As can be seen in these two examples, irony and humour are devices that may function as affiliative strategies, as they seem to reassure the patient and, at the same time, the follow-up comments are related to the story-telling of the problem itself, so that patients, after affiliative humour, seem more cooperative. "You're a bad woman" also reflects the paternalistic nature of the physician's speech, as a person who qualifies behaviour as either good or bad.

Even though the examples selected are very different in nature and located at different stages in the interaction, they share the fact that they are initially uttered by the doctor, with a subsequent positive follow-up on the side of the patient. It is clearly an example of how the doctor tries to reassure the patient and makes use of what Cordella (2004:131) calls *Fellow Human Voice*, i.e., showing empathy and emotional reciprocity with the patient. In this sense, this affiliative strategy appears

as an integrated part in the discourse itself, and therefore in relation to the main goal participants have (solving a health problem). In this sense, this affiliative strategy has both a transactional and interactional goal: it is transactional because it helps the patient understand the seriousness of the health problem or reassure him/her in order to obtain accurate information or let the doctor do their job properly when examining the patient, for instance. At the same time, it has the interactional goal of achieving a relaxed atmosphere in which the relational work at stake ends without much problem at the same time that the management of rapport is to be maintained or enhanced. It is, then, an affiliative strategy that may be helpful in doctor-patient interactions in the British setting.

5. 2. SMALL TALK[6] IN MEDICAL CONSULTATIONS.

Whereas the most salient interpersonal feature of British interactions is the use of humour, this feature is scarce in Spanish data (only one case found). In turn, Spanish medical encounters show a high frequency of phatic communication as a way of maintaining and reinforcing doctor-patient relationship. Within this category, we may highlight small talk in the form of the patients' unsolicited personal information. In fact, six out of the ten interactions analyzed show this feature in communication, where patients usually engage in a conversation which is not necessarily related to the main health problem nor it is information which has been required at any point of the interaction; it is, in fact, a silence filler, a way to socialize with the doctor once he/she is busy printing a prescription or examining the patient in silence. Data show that patients not only tell the doctor personal information that is not necessarily relevant to achieve transactional goals, but they do in fact help manage interaction, as the doctor may find way to give advice or express his/her own opinion. In interaction 3, we find both examples: first, the patient explains what her child will do, and second, she asks personal information to the doctor, in order to show empathy and personal interest:

(3) Spanish consultations

D -Le pones calor seco con una mantita eléctrica o bolsa de agua caliente o con el secador cinco o diez minutos y después le das una crema dos o tres veces al día y que haga un poquito de reposo, ¿eh?

(use heat with an electric blanket or a hot water bottle or with a dryer during five or ten minutes and then put some cream on two or three times a day and he should take a rest, ok?)

P -Sí, eso último será lo peor / porque ayer le dolía pero la bici la cogió.

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[6] The term 'small talk' has been taken from Coupland (2000).

(yeah, the last bit will be the worst / because yestesday he was in pain but he took his bike ..)

D hombre, conviene que no hagas ahora mucho ejercicio/ si no/ va a tardar mucho en curar.

(lad, it is important that you don't do much exercise / otherwise / it is not going to heal for a long time).

P Don José, es verdad que se va usted/ o::

(Mr. José, is it true that you are leaving, or::?)

D Pues es que, como está el tema, eh, así es que no podemos, ya es que si no, si no puedo ver a la gente con tranquilidad y con

(Err, seeing how things are going, we cannot work, I can no longer see people with plenty of time)

P de verdad

(really?)

D si se arregla me quedo (1) si no / pues me iré.

(if everything is sorted out, I'll stay (1) otherwise / I'll leave.

P bueno/ pues nada / buenos días.

(OK / then/ good morning).

As can be seen, the initiative in this case has been taken by the patient. This happens in all the interactions where small talk is used as a device. Usually, the doctor acknowledges the dissertation made by the patients, responds to it, and then continues with the main issue in the encounter. This is similar to interaction (4), where the patient relates the main topic to others that may be of interest for the doctor:

(4) Spanish Consultations.

P Hola, buenos días.

(hello, good morning)

D Buenos días.

(good morning)

P Vengo porque tengo un dolor de garganta:::

(I've come because I have a sorethroat)

[…]

P a ver si puede ser que yo me cure porque estoy con la acupuntura pero la acupuntura tampoco tiene que ver con usted, la verdad, pero es que últimamente es todo cosa física.

(I hope I can get better because I am know with acupunture as well, but acupunture is not related to you, isn't it, but in the last days everything is about physical things).

What is also significant here is that, in contrast, the information provided by British patients tends to be subject to what the doctor strictly asks, as can be seen in interaction (5):

(5) British consultations:

D [1] What can I do for you this morning?

P [2] Well I'm still getting myself in a tangle, like I was when I came.

D [3] Right.

P [4] But I didn't take those tablets, I tried not to do.

D [5] That's the low dose Dizapac

P [6] Yeah, whatever it is.

D [7] Yeah.

[…]

D [15] Aha.
[16] Any idea what's brought that on?

P [17] I don't really know, I've had it for about three week.
[18] I keep trying one of those lamps.

D [19] Yeah.
[20] Okay, let's have a closer look at that arm.

[…]

P [25] Are you jogging?

D [26] No no.
[27] Just normal summer ware.

P [28] I'd thought you'd been getting exercise in.

D [29] No no no no no no no, no just casual ware this summer.
[30] It's too hot otherwise.
[31] It's hot enough as it is in this place.
[32] I've got three internal walls and the wall's about eighteen inches thick with a double glazed window.
[33] I mean there's You know what [...]

As can be seen, the information provided by the patient is usually solicited by the doctor, and is usually related to the main health topic. In turn, Spanish patients usually provide information prior the doctor's intervention in many occasions. Interacions (3) and (4) are two typical examples that show that the patient is the one who deliberately decides to introduce affiliative strategies with the doctor. In this case, then, it is not a need to reassure anyone; rather, it is a matter of what Cordella (1999) and Triandis *et al.* (1984) identify as 'simpatía', a concept which has no equivalent in English but refers to a permanent personal quality where an individual is perceived as likeable, attractive, fun to be with, and easygoing" (Triandis *et al.,* 1984: 1363). As Cordella (1999) explains, interactions in the Spanish-speaking world are characterized by displaying friendship and camaraderie, at least in this kind of asymmetrical exchange.

In relation to this, it is clear that the main affiliative strategies found in both corpora not only vary linguistically, but also in behavioural terms; in the British case it is the doctor who, as an attempt to manage a (potential) tension due to the problem-solving nature of the exchange, decides to introduce a joke, an ironic comment and so on to manage the situation properly. It is the doctor, the one considered to have power in the interaction, who deliberately decides to show certain closeness. However, humour is not related to personal issues or information. Rather, it is developed in line with the main topic (health), and in this sense, it is a strategy embedded in the frame of medical consultations. On the other hand, the Spanish case shows a situation where it is the patient, not the doctor, who introduces affiliative expressions in the form of personal information, usually unsolicited and spontaneously. Also, the situation is given once the main transaction (that is, explaining the health problem and diagnosing) has occurred, and once the doctor is busy doing any manual activity that does not require interacting with the patient (e.g., writing or printing the prescription, looking for a specific medicine, filling a report, examining the patient), which means that it is a way of managing rapport and therefore, showing friendliness with the doctor.. Both cases reveal that the way of maintaining or reinforcing rapport not only vary in its thematic and structural nature, but also in who initiates this and how. This will have clear consequences in the conceptualization of the rights and obligations assumed as appropriate in medical encounters.

Needless to say, these affiliative features may reveal different attitudes in different cultures, and it is attitudes that may reveal something about those underlying principles in interaction that may guide behaviour (Sociopragamatic Interactional Principles or SIPs), depending on what is considered appropriate or not. In the Spanish data, for instance, patients show a clear tendency towards affiliation and closeness, whereas British patients prefer to stick to clear responses to the doctor's requests and questions. On the other hand, we may say that whereas the Spanish doctors are more oriented towards the task itself (they focus on the transaction while patients develop phatic talk), the British doctors show orientation

towards the other, in a way that humour, for instance, is useful to show this attitude. This is summarized in Figure 2:

	Spanish consultations		**Bristish consultations**	**Pragmalinguistic features**
Patient	Affiliation, closeness	----------	Restraint, Formality	Phatic communication
Doctor	Oriented towards content	----------	Oriented towards addressee	Humour

Figure 2: Some SIPs associated to Spanish and British medical encounters.

These results are also supported by Hernández López & Placencia (2004) and House (2000). The first study revealed that Spanish usually show closeness with the interlocutor in comparison to British individuals in the context of service encounters. It is the case in patients here. As for House's (2000) study in comparing British and German speakers, she also found that there are different patterns or cultural dimensions influencing communication; one of them was clearly the orientation towards the content for German speakers when compared to the British counterparts, who showed to be more oriented towards the addressee. This is the case for doctors in the present study.

6. DISCUSSION

The results show that there are clear differences in relation to the SIPs held as appropriate in these two cultures. But, what do affiliative strategies say about rights and obligations? According to Spencer-Oatey (2008), these SIPs directly depend on the sociality rights and obligations that interlocutors consider appropriate in this context, and which can be related to equity rights (we are entitled to be treated fairly as individuals) and association rights (we are entitled to association with others as member of a group). Taking this into account, this study reveals that cultures cannot be classified as black or white, as it depends not only on the situation but also on who says what. In particular, data show that whereas Spanish patients' main SIP is related to association rights (and linguistically codified as phatic communication) with doctors, it is doctors in the British case who develop this. In turn, British patients show more formality in their way of interacting and seem to stick to equity rights given by the situation itself and the role developed as patients. The fact that the Spanish doctors are more oriented towards the task whilst English doctors are also oriented towards the other, also shows a different way of perceiving equity and association rights and obligations. This can be interpreted as

such if we consider that the way interlocutors interact show certain aspects of their attitudes and perceptions of the interaction.

Thus, we may say that rights and obligations in the British consultations are mainly given by the institutionalized situation where doctors hold the power (mainly *expert power* and *legitimate power*, as named by French and Raven, 1959). In this sense, patients wait to be 'guided' in interaction and it is doctors that ask questions, give suggestions, develop interactional work, use affiliative strategies and initiate turns, as supported by Fisher and Groce (1991) and Coupland and Coupland (1984). It is the right of the clients (or patients) to be assisted and treated fairly. They are the clients and also the ones who may have a satisfactory result at the end. It is the obligation of the doctor to diagnose and provide treatments, but also, as data showed, consider that, since the physician is the one controlling and showing power in this context, he/ she is the one taking the initiative in displaying rapport enhancement features.

In contrast, Spanish interactions are of very different nature. There is the assumed power given by the institution, where doctors may diagnose and provide treatments, but it is mainly patients who interactionally develop interpersonal work and rapport enhancement activities. In this sense, it is the right of the patients to be listened to and to express themselves. Also, if we consider that it is the obligation of patients to be cooperative in order to achieve interactional goals successfully, the affiliative attitude shown through phatic communication may be viewed as part of their obligation of being friendly with the person helping. As expressed before, this idea has been supported by Triandis *et al.* (1984) and Cordella (2000), among others, who talked about the concept of *simpatía* as a characteristic of hispanic interactions. By *simpatia* it is understood that individuals want to be seen as friendly and likeable, usually by showing closeness and camaraderie. This attitude displayed by Spanish patients can also be related to the term *confianza* (Bravo, 2001), which implies that Spanish interlocutors tend to minimize power barriers in communication and display, in turn, affiliative strategies. In this sense, we may say that whereas British interactions reflect clear cut categories in terms of institutional rights and obligations, Spanish interactions are more dynamically shaped by the individual choice of the individuals. In this sense, the institutional setting does not constrain the interlocutor to such extent and there is room for informality on the side of patients, at the same time that doctors positively acknowledge this fact. By considering their reactions, it is clear that the Spanish patients' attitudes are not taken as power being supplanted. All in all, rights and obligations in British interactions are clear-cut, whereas Spanish rights and obligations not only are more dynamic and flexible, but also show that power relations can be easily minimized and accepted by both parties in interaction.

In this sense, by considering both pragmalinguistic features of interaction (humour and phatic communication) and sociopragmatic aspects (reactions and attitudes displayed through interaction) some Rapport Management aspects such as

sociality rights and obligations may be unraveled and interpreted in different settings, as summarized in Figure 3:

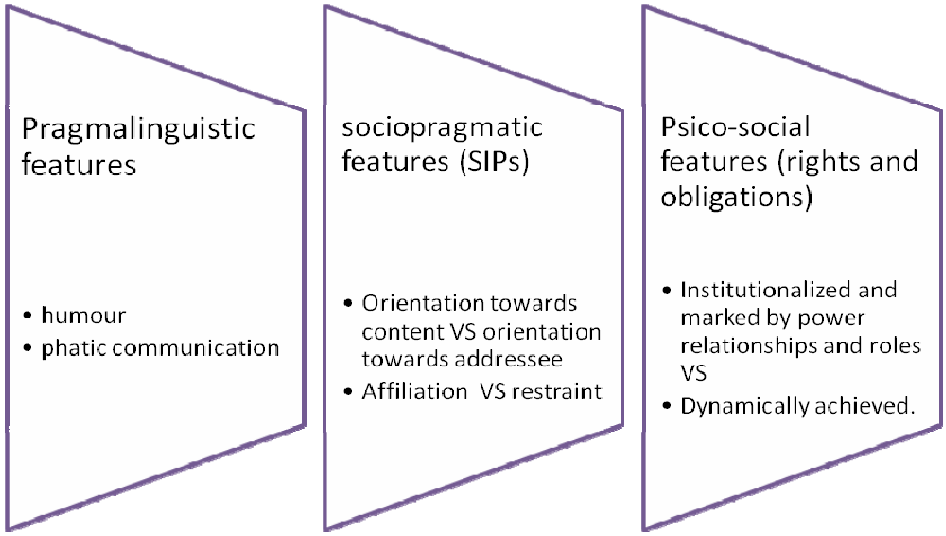

Figure 3: Relationship between pragmalinguistic, sociopragmatic and psico-social aspects of interaction in the present study.

7. CONCLUSION

This paper has examined how, even in two distant societies with varying sociopragmatic principles underlying communication, it is possible to find strategies showing similar orientations, such as closeness to the interlocutor. However, the way they are performed, who performs them and with what intention, is something that greatly varies from culture to culture. In particular, even though there are studies showing that British English is characterized by formality and restraint in comparison to other languages such as Greek (Sifianou, 1992), German (House, 2000, 2003) or Spanish (Hernández-López y Placencia, 2004; Hickey and Stewart, 2005), one should not forget whether these strategies are displayed by both interactants or one of them. Also, the main goal of displaying whichever orientation is at stake should be considered, so as to know whether, let us say, affiliative strategies are a way of socializing and showing *simpatía* with others or whether it is a way of reassuring patients in medical encounters. Thus, who says what, how and with what interactional goal will help understand the underlying motivations interlocutors have in communication. In this case, the results show how there is variation in the conceptualization of rights and obligations. All this may in turn reflect cultural and ideological orientations that cultures contain

(Hofstede 1994, 2001, 2007). As a consequence, not only linguistic structures should be taken into consideration, but also their relationship with more abstract concepts such as power and the under-examined concept of rights and obligations that Spencer-Oatey (2000, 2008) proposes as having the same status as face when managing rapport. In this vein, RM theory shows that certain motivations can be explained in interaction and that more empirical studies are needed in order to provide a full account of this in a variety of contexts. By looking at the attitudes interlocutors display in real data, the interconnection between purely linguistic and perceptual aspects of communication can be interpreted and explained.

What all this means is that the existing relationship between linguistic structures, sociopragmatic behaviour, rapport management and cultural values is undeniable: depending on certain cultural values, individuals will build their bases of rapport (face, rights and obligations and interactional goals) which in turn will be represented in language as SIPs that may be unraveled as specific linguistic structures or pragmatic phenomena. It corresponds to the image of an iceberg where what is uttered and perceived is a small portion of what really motivates the way communication is developed.