Chapter 11

Pragmatics: Leadership and team communication in emergency medicine training

Sarah Atkins and Małgorzata Chałupnik

1. Introduction

This volume showcases a number of analytic approaches that have contributed to the richly inter-disciplinary study of communication in healthcare. Few are broader, perhaps, than the approach of 'pragmatics', which encompasses a number of theories and frameworks under an overarching principle of understanding language and meaning in its context of use. This chapter addresses how some pragmatic theories have been applied to the study of healthcare communication, focussing in particular on achieving tasks through spoken interaction in medical contexts.

A definition and overview for the field of pragmatics are provided in the Background, section 2. Following this, section 3 provides a case study of a pragmatic approach to understanding spoken communication in simulated emergency medical teams, analysing the performance of requests in this educational context. Drawing on pragmatic concepts of 'speech acts', 'politeness' and 'indirectness', the case study addresses how healthcare professionals accomplish the joint requirements of communicating quickly and efficiently, while also building effective relationships amongst team members. We conclude by discussing how the linguistic field of pragmatics can usefully contribute to the study of healthcare communication.

2. Background

Although it is not possible to cover the field of pragmatics comprehensively in this overview, we outline some key topics and applications. The focus is largely on applications to spoken communication, in line with much of the early work of pragmatics, but it should be noted that, although beyond the scope of this chapter, pragmatic studies of language also extend to written and digital communicative modes.

2.1. What is pragmatics?

Pragmatics is an approach to understanding language and meaning that places *context* at the centre of analysis, whether that be situational (what speakers know from their immediate surroundings), background knowledge (what speakers know of each other and the world) and co-textual (what they know about what has already been said) (Cutting, 2008: 3). It is an approach that does not assume a one-to-one relationship between the form of an utterance and its function, but rather looks to contextual factors to interpret an utterance and its meaning to speakers and hearers (Leech, 2014: ix). The value of this approach can be seen in the multiple meanings a single grammatical expression might carry; for example, 'It's cold' could be interpreted as a comment on the weather or a request that someone shut a window, depending on context. A speaker can also imply a meaning that is somewhat different to the literal meaning of the words uttered, through strategies such as sarcasm, hyperbole or indirectness.

Pragmatics has therefore been defined as 'the study of the relationships between linguistic forms and users of those forms' (Yule, 1996: 4). In contrast to semantics, another sub-field of linguistics addressing 'meaning', pragmatics addresses how people use language to 'get things done' in real interactional contexts.

In practice, this broad description has encompassed many different theories and concepts. This has sometimes led to difficulties in pinning down a definition since, as Verschueren (2009: 9) suggests, 'pragmatics sometimes looks like a repository of extremely interesting but separable topics such as deixis, implicature, presupposition, speech acts, conversation, politeness, and relevance'. Though not exhaustive in our overview, two key pragmatic concepts, their commonalities and their applications to health communication are outlined further below: (1) speech act theory (2) politeness and rapport. We will touch on difficulties the field has encountered and the intersection of pragmatics with other approaches in linguistics.

2.2. Speech acts in healthcare

Speech act theory conceptualises how actions are achieved through talk or how we 'do things with words' (Austin, 1962), emphasising the performative role of language in the social world. Speech acts describe the functions performed by utterances, such as 'requesting', 'criticising', 'apologising', capturing the pragmatic phenomenon of a range of different linguistic forms being able to perform the same essential function. A speech act can be broken down to the

- 'locutionary act' - uttering a sequence of words, such as 'It's cold'.
- 'illocutionary act' - the action it performs, such as making a request that the hearer shut a window, sometimes called the 'illocutionary force' of an utterance.
- 'perlocutionary act' - the effect achieved on the hearer achieved by performing the act, for example that a hearer interprets 'It's cold' as a request to shut the window and does so.

A number of taxonomies for types of speech act have been proposed, including Austin (1962), and Searle's (1976, 1979) influential categorisations of five key acts – directives, expressives, representatives, commissives and declarations. The focus for our case study in section 3 will be on 'requesting' in emergency medical scenarios, which falls under Searle's (1976: 11) category of 'directives', defined as 'attempts […] by the speaker to get the hearer to do something'.

In research on medical encounters, only a small number specifically address speech act theory, but there exists a wide range of related research influenced by this approach. A classic study on directives between doctors and patients is that of West (1998), who looked at differences in the utterances used by male and female doctors. West found that female doctors used many more linguistic forms which minimised status differences when issuing directives, supporting a stereotype that women are likely to be more interactionally cooperative. Research into speech acts in the workplace more generally has also touched on

medical settings. Ervin-Tripp (1976), for example, studied interactions in some professional settings, including healthcare, finding variation in the form of utterances according to the relationships or status differences between speakers.

The extensive study of questions in the medical encounter has relevance to an understanding of speech acts. Stenström (1984), West (1984) and Frankel (1979) all examine how requests for information are enacted in doctor-patient communication, which can be achieved by a huge variety of linguistic forms. Typically, doctors are found to perform many more questions than the patient (West, 1984), demonstrating this as an act which may exert power over the patient. Frankel (1979), for instance, found that fewer than 1% of the total number of questions in the medical consultation were 'patient-initiated'. Although conceptualising the asymmetric relationship of communication between patients and health professionals has proven difficult (see Pilnick and Dingwall, 2011 for discussion), the essential claim that the manner of performing a speech act is linked to underlying social relationships between speakers has been of huge importance to theories of politeness and rapport, outlined further in section 2.4.

Many of these studies on 'questions' move into the methodology of conversation analysis (CA) rather than speech acts (see Barnes and van der Scheer, this volume). Key principles of CA relevant to pragmatic approaches to interaction, particularly the notion that an utterance can only be understood in terms of how it functions in use. CA examines this closely in an interactional context, using prior and subsequent turns by speakers to make sense of the particular action performed. The methodology of CA may be a means of tackling some of the problems with speech act theory, particularly the way that the works of Austin (1962), Searle (1976, 1979) analyse utterances in isolation rather than as interactive phenomenon. Conversation analytic approaches are able to avoid an intentionalist thesis of 'speech acts' and instead address utterances in their sequential, interactional environment. Such an empirical approach can reveal linguistic phenomena that are not possible to hypothesise.

Blum-Kulka et al.'s (1989) pragmatic taxonomy for speech acts, which we explore further in our own case study below, also represents an attempt to look beyond the isolated utterances of Austin and Searle, and identify their function within a broader context. Briefly, Blum-Kulka et al.'s 'Cross-Cultural Study of Speech Act Realization Patterns' (CCSARP) framework aims to 'complement theoretical studies of speech acts, based primarily on intuited data of isolated utterances, with empirical studies, produced by native speakers in context' (Blum-Kulka et al., 1989: 3), examining the ways in which preceding and subsequent utterances can work to soften a speech act. Nevertheless, Blum-Kulka et al.'s (1989) work still relies on elicited data and is a pragmatic framework that has not been applied in healthcare contexts. In adapting the framework to apply to a spoken medical context in section 3, we address this limitation and make the case that this coding scheme can provide a constructive means of systematically analysing speech acts as they achieve tasks in real-time interaction.

2.3. Politeness and (in)directness in healthcare

A much larger body of pragmatics research in healthcare has addressed the phenomenon of 'politeness'. Linguistic theories in this area have been extensively developed, with a wealth of differing definitions, including 'politeness' (Brown and Levinson, 1987), 'rapport management' (Spencer-Oatey, 2000), 'relational work' (Locher, 2004) and 'relational practice' (Holmes and Marra, 2004).

In essence, politeness theory examines how our interactional choices are guided by the maintenance of interpersonal relationships, a key criterion when considering the variation in the linguistic expression of speech acts outlined above. In the classic Brown and Levinson (1987) work, these relational requirements on interaction are conceptualised through attendance to the hearer's needs. Drawing on the concept of 'face' (Goffman, 1981), the public self-image that we wish to maintain in interaction, Brown and Levinson (1987) developed a model whereby certain actions, such as requests or criticism, are intrinsically threating to a hearer's face ('face threatening acts' or FTAs). They can damage either 'negative face' (the desire for autonomy) or 'positive face' wants (the desire to be evaluated positively by others). Speakers have a range of linguistic choices open to them when making an FTA. They can perform the act 'on record' (e.g. 'Can you shut the window') or 'off record', such as a request made indirectly (e.g. 'it's cold in here.'), linking to speech act theory and cases 'in which one illocutionary act is performed indirectly by way of performing another' (Searle 1975: 60). If made on record, the FTA can be performed with little or no redressive action to minimize face threat ('Shut the window!') or the speaker can attempt to minimize social damage to face, through 'negative politeness', attending to the hearer's desire not to be imposed upon (e.g. 'if you don't mind, please could you shut the window') or showing attention to the hearer's desire to be liked (e.g. 'I love how you've decorated this room! Could we shut the window though?'). These choices will be guided by the context and relationship between the speakers including power relations. 'Requesting' action from another interactant, which will be the focus of the of the case study below, is intrinsically threatening to a hearer's face (Brown and Levinson, 1987: 66) and can therefore be softened through a variety of linguistic strategies, which we examine.

Brown and Levinson's (1987) politeness theory was employed contemporaneously in some healthcare contexts. This includes Robins and Wolf (1988), who identified how medical students repair conversational difficulties in patient interaction, and Aronsson and Rundstroem (1989), who foregrounded politeness between doctors and parents discussing a child's allergies. Many studies in healthcare communication employ multiple methodologies rather than explicitly focusing on politeness theory, but do make use of the notion of 'face'. Aisworth-Vaugn's (1998), for example, uses the concept of the 'face-threatening act' in combination with sociolinguistics to study how healthcare professionals and patients negotiate asymmetrical power in interaction. Locher's (2006) work on advice-giving in an online help forum for young people, shows the value of applying the concept of 'face' in digital communication. She finds a mixture of several forms used by the forum's online counsellor, including indirect strategies and bald, on record directives, to perform relational facework with the addressee (Locher, 2006: 98-100). Combining tenets from pragmatics with other analytic methodologies is characteristic of many studies in healthcare communication then, making the disciplinary boundaries for pragmatics difficult to entirely delineate.

Concepts of politeness, face and (in)directness have developed extensively since Brown and Levinson's (1987) classic work, highlighting many contexts, motivations and cultures in which directness between speakers may flout this model. Criticisms have been levelled against the binary distinction between 'positive' and 'negative' face, particularly in non-Western cultural contexts (e.g. Matsumoto, 1988; Wierzbicka, 2003), challenging Brown and Levinson's (1987) claims to 'universality' and that particular, fixed linguistic forms are perceived as 'polite' by language users (Watts, 2003). The assumption that we are always motivated to attend to speaker's face wants has also been challenged, particularly in the research on impoliteness (Culpeper, 2005; Bousfield, 2008).

Notwithstanding these developments, we argue that a fundamental assumption has remained from Brown and Levinson (1987) that is crucial to our case study on emergency medicine: that the need for efficiency in more urgent contexts of communication warrants the use of directness, enabling a tacit agreement between speakers that face wants can be sidestepped (Brown and Levinson, 1987: 95). This assumption holds in the majority of studies of communication between medical teams, where clarity and directness are key recommendations:

> politeness taxes mental resources and creates confusion about what is truly meant during interactions. While this confusion can be useful in low-stakes situations, it can have negative, even dangerous consequences in high-stakes situations
>
> (Bonnefon, Feeney and Neys, 2011: 321)

Politeness and rapport in emergency medical settings are therefore worth investigation. In a 2009 special edition of the *Journal of Politeness Research*, Mullany (2009: 1) points out that 'there is a real necessity for empirical investigations to be produced in a wide variety of healthcare contexts', employing the theories of politeness that have been applied to other institutional settings. A decade on, Locher and Schnurr (2017) argue that there is still much to be researched. The importance of fostering rapport with patients in emergency settings has been highlighted (Rosenzweig, 1993), but the means of achieving rapport with other members of a medical team, in a manner that also aids efficiency, has received less attention. Slade et al. (2008) compare functions performed by doctors and nurses in dialogue with patients in an Emergency Department, finding that nurses attended to the interpersonal relationship with the patient more than doctors did. However, given that their study suggests work and clinical outcomes in emergency settings is 'dependent on numerous other professional expertises and practices,' in a chain of care (Slade et al., 2008: 273), it is worth investigating the inter-professional, collaborative communication between team members further, as our case study below attempts.

2.4 Difficulties with defining pragmatic approaches

Even with this partial overview, it is possible to see the breadth of topics in pragmatics and how they have been combined with cognate methodologies, particularly in multi-disciplinary healthcare communication studies. This breadth presents difficulties and Crystal (1997) has

suggested that pragmatics is ‘not as yet a coherent field of study’. In healthcare, Davis (2010) argues that,

> [a] major challenge in tracing interpersonal pragmatics in health discourse is that within the majority of the studies focused on language in medical settings, pragmatics constructs are seldom the explicit or exclusive focus, though they may be a part of the larger discussion. Instead, pragmatics is more typically embedded within studies combining a variety of theoretical approaches from discourse, sociolinguistics, conversation analysis (CA) and ethnography…
>
> (Davis, 2010: 381)

As Davis suggests, it may be that many of these approaches are much closer than practitioners have sometimes acknowledged. We have traced some overlaps with other methodologies during this overview and, like many pragmatic studies of healthcare communication, our own case study draws both on pragmatic concepts of speech acts and politeness, as well as related methods for analysing spoken interaction.

3. Case study: The pragmatics of leadership and collaboration in emergency medicine training

In illustrating how pragmatics can be applied, we draw on a larger study (Chałupnik and Atkins, 2020), which analyses simulated interactions in multi-disciplinary teams for training in emergency medicine, using an adapted model of Blum-Kulka et al’s (1989) coding framework. In doing so, we explore the link between the linguistic choices that healthcare professionals make, particularly indirectness, and the implications of these choices for the team interaction and the achievement of time-pressured tasks. By examining the linguistic expression of task delegation, subsequent uptake by the team and the overall speed with which all clinical tasks are performed, the chapter addresses the extent to which different pragmatic requesting strategies are tied to ‘efficiency’, highlighting the value of employing principles from pragmatics in the study of healthcare communication.

3.1 Background to the study

The simulated trauma scenarios analysed here are designed to prepare UK trainee doctors for their summative exams to specialise in emergency medicine. Similar to objective structured clinical examinations (OSCEs), the simulated interactions involve the completion of a timed station ‘where a standardized clinical task is performed under the observation of one or two examiners who score the performance on a structured marking sheet’ (Newble, 2004: 200). The discourse of simulated scenarios has been described as a hybrid one, merging elements of talk observed in in real clinical interaction but also demonstrating distinct qualities of its own (Atkins, 2019). Although simulated trauma scenarios have some limitations, they are frequently employed in medical education, providing a relatively safe environment for professional socialisation and practice formation for trainee doctors (Sarangi and Roberts, 1999), as well as the development of profession-specific clinical and communication skills.

In preparing trainee doctors for practice, simulated team scenarios usually entail an assessment of interprofessional communication, reflecting the wider phenomenon of healthcare becoming increasingly team-based and multi-disciplinary (Villagran and Baldwin, 2014). This reflects a wider concern with achieving efficient coordination between multiple specialisms (Department of Health 2002; Dreachslin et al., 2000). Nevertheless, the benefits of team care are contingent upon achieving that effective coordination, including through communication. When problem-solving, ad hoc medical teams, in particular, need to develop effective ways to share information, engage in decision-making and jointly achieve clinical tasks. The role played by language in coordinated care makes the context of medical education and training of junior doctors a fruitful one to explore, since it is medical education that is instrumental in establishing and reinforcing the norms of professional practice (Roberts, 2007: 256). These simulations give some insight into the inter-professional communicative practices junior doctors develop and the subsequent assessment of their performances by an examiner gives an indication of practices that are most valued.

3.2 Data

We analyse video recordings of seven trauma simulations and subsequent debrief sessions, filmed in the training suite of large teaching hospital in the UK. The audio-visual data was supplemented by training documentation, including the description of the trauma scenario, briefing notes for its participants and the assessment criteria used by a senior healthcare professional evaluating the performance of the trainees. The scenario is a trauma case in which an unidentified individual, found earlier next to a crashed car, is admitted to an emergency department (ED). In the scenario, trainee doctors must demonstrate leadership skills in managing their team of medical professionals and delegate tasks to team members. They must perform the clinical tasks outlined in the marking sheet, including examining the patient and successfully identifying internal bleeding, before dispatching the patient to an operating theatre, all within the allotted fourteen minute time limit. Both the clinical and communicative elements of trainees' performances are assessed as part of scenario.

The interactional participants include actors and healthcare professionals: actors play the roles of the patient and the paramedic, while four healthcare professionals play the roles of members of the medical team – a foundation doctor (F2) and a nurse – as well as, later in the scenario, a surgical consultant and a radiographer (Figure 1).

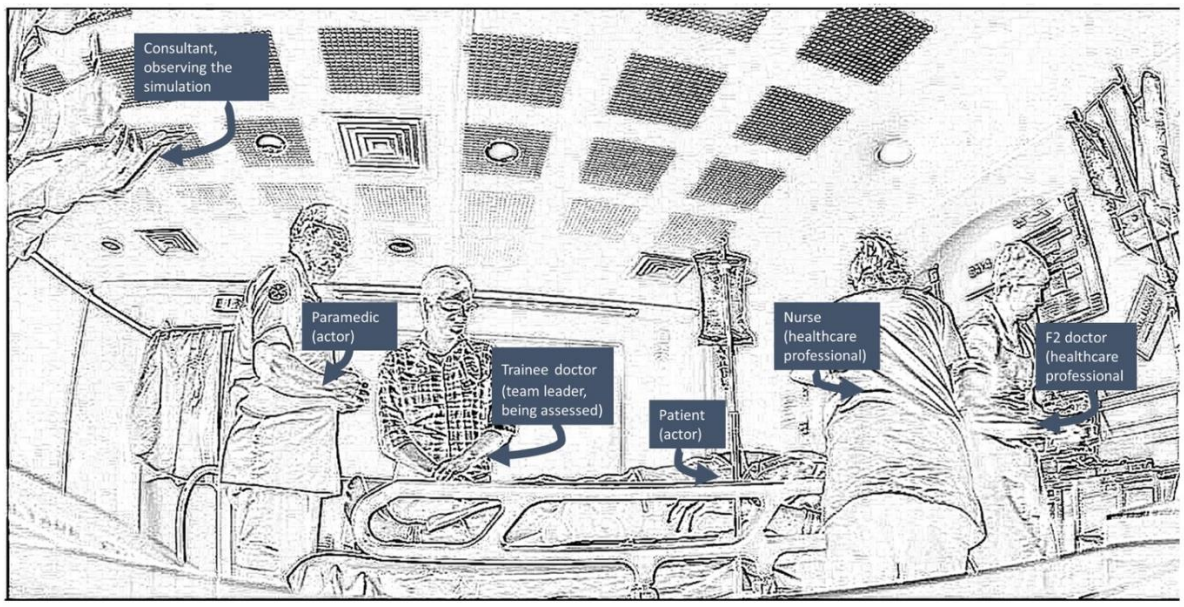

Figure 1: Main participants of the simulation

After each simulation, the observing consultant completes a marking sheet, requesting an evaluation of the trainee's leadership skills from each of those in the team. The evaluation is recorded both in numerical form, on a scale of 1-5 where 5 is the most favourable evaluation, and as a descriptive commentary, with the healthcare professionals describing how the candidate performed. Based on this assessment, we categorise the seven trainees into three groups. The three candidates given the highest mark of 5 and receiving very positive comments are labelled here as 'high performers'. All 'high performers' complete the key clinical tasks within or ahead of the allotted 14 minutes (see Table 1). The 'good performers' consist of three trainee doctors who receive marks ranging from 4.5 and 3.5 and generally positive commentary from the simulation participants. Some do complete the key clinical tasks in the station within the allotted time, but not in every case. Out of the seven trainees, one candidate receives significantly less favourable evaluation, with a participant stating afterwards 'I didn't really know what to be doing most of the time'. While no marks were mentioned during his debrief, he is given a lower overall mark and the commentary made in relation to this candidate's performance is poor. This trainee doctor only completes some of the clinical tasks listed in the marking sheet.

Table 1: Station completion times

	Candidate	**Station completion time**	**All of the key clinical tasks performed (Yes/No)**
High performers	Candidate A	13:50	Yes
	Candidate B	12:03	Yes
	Candidate C	10:58	Yes
Good performers	Candidate D	12:36	Yes
	Candidate E	14:00	No
	Candidate F	14:00	No

Candidate assessed less favourably	Candidate G	14:00	No

We analyse the communicative and clinical performance of each trainee. Through differentiating their linguistic choices, specifically the ways in which their requests are formulated, we aim to establish pragmalinguistic features associated with positive evaluation of leadership skills, as well as positive responses *within* the interaction, as realised by the successful completion of a particular task and the station overall. In doing so, we aim to demonstrate the value of linguistic analysis informed by pragmatics, particularly in understanding the performance and assessment of leadership in medical settings as being to a great degree a linguistic – and more specifically a pragmatic – phenomenon.

3.3 Analytical framework

To assess the pragmatic forms employed in task delegation, we draw upon the pragmatic theory of speech acts outlined in section 2 (Austin, 1962; Searle, 1969). The speech acts analysed are directives – 'attempts […] by the speaker to get the hearer to do something' (Searle, 1976:11) – and specifically requests for action, defined by Blum-Kulka et al. (1989: 11) as 'pre-event act[s]' that express 'the speaker's expectation of the hearer with regards to some prospective action'. The types of requests for action identified in the data are considered as a means for these trainee doctors' to enact leadership, in line with the assertions made by professional communication scholars who view task allocation as a prototypical form of the enactment of leadership (see Schnurr, 2009; Baxter, 2015).

We consider the different forms the requests for action take, drawing upon a modified version of an existing taxonomy. In line with Blum-Kulka et al.'s (1989) CCSARP ('Cross-Cultural Study of Speech Act Realization Patterns') coding scheme, we outline two components of requests: i) head acts and ii) their internal and external modification (Tables 2 and 3). Following Blum-Kulka et al. (1989), the head act is the component which independently realises a speech act, either directly or indirectly (Table 2). Internal modification is then a collection of devices that "modify the impact of an utterance" (Vine, 2004: 93) that are internal to the head act (Table 3). External modification ('supportive moves' in the original taxonomy), on the other hand, provide means of strengthening or softening the force of the request through elements before or after the head act (terms listed in Table 3). Examples of each of these structural components are given with excerpts taken from our data.

Table 2:Types of requesting head acts (based on Blum-Kulka et al., 1989)

	Strategy	**Example**
Direct	*Mood derivable*	*Get me an F2.*
	Obligation statement	*We need to get someone to come down and put a drain in.*
	Want statement	*Just want to get a chest x-ray.*
Conventionally indirect	*Suggestory formulae*	*Let's make sure we've got the chest drain trolley.*

	Query preparatory	*Can we put the trauma call in?*
	Hint	*You did give me a GAS but I don't think I actually did [see it].*

Table 3: Internal and external modification of head acts (based on Blum-Kulka et al., 1989)

Internal modification	*Lexical*	
	a) Hedging	Could you **perhaps** help?
	b) Understaters	Linda, can you **just** let radiology know that we'll need an x-ray?
	c) Subjectivisers	John, can you get IV access **for me**?
	d) Downtoners	We should **probably** put in a drain on the right-hand side.
	e) Politeness markers (conventionalised forms)	Can we get a handover then, **please**?
	f) Collective pronouns	**We** need to activate major haemorrhage protocol.
	g) Time intensifiers	Okay, so we need to transfuse him **straight away**.
External modification (supportive moves)	*Preparator*	**Have we got a trauma team here?** Can we put a trauma call out?
	Grounders	So, **if they haven't arrived then**… yes, let's get him down so we can do a DPL.
	Disarmers	I'm sorry… **you're busy** but can we get some fluids ready as well?
	Promises of reward	If we can get the chest drain in then **that would be fantastic**.
	Imposition downgraders	I think we should probably put a binder on his pelvis guys **when we get a chance**.
	Appealer	Set him up in here before we start. **Is that alright?**

The choice of how directly or indirectly the request is expressed and how mitigated or strengthened the request is will be often dependent upon interpersonal concerns and the specific pragmalinguistic conventions associated with how such concerns are expressed in the socio-cultural context. Existing literature on requests in British English-speaking contexts, for example, highlights that these are more likely to take indirect forms when person-orientated factors are at stake (Blum-Kulka, 1987; Lorenzo-Dus and Bou-Franch, 2013), with the speakers of British English – and specifically speakers of British English from a particular social class (for discussion, see Mills, 2017) – often displaying more orientation towards deferential politeness than it would be visible in other contexts. While assuming no rigid interrelationship between linguistic form and the evaluation of its politeness, we will consider the extent to which these interpersonal and socio-cultural orientations play out in our data and the implications this has for task- and person-orientated aspects of communication in this medical training context.

3.4 Analysis

Overall patterns

Through coding the data from the seven trauma simulations using the modified version of the framework outlined above (Blum-Kulka et al., 1989) it appeared that the more positive evaluation of leadership skills was associated with greater use of supportive moves when making requests (3). The trainee doctors whose leadership performance was evaluated often performed requests in indirect and downgraded ways, more frequently in fact than direct requests. The candidate whose leadership performance was assessed least favourably, on the other hand, used a greater number of requesting strategies that were unmitigated and direct.

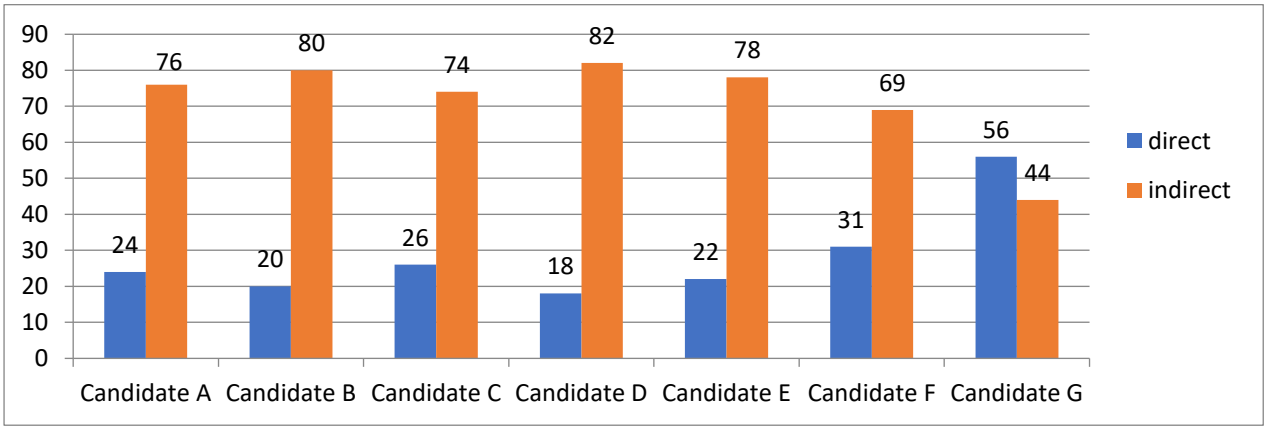

Figure 2: Percentage of direct versus indirect requests employed by each trainee doctor (candidates ordered by evaluation of their leadership – highest to lowest score)

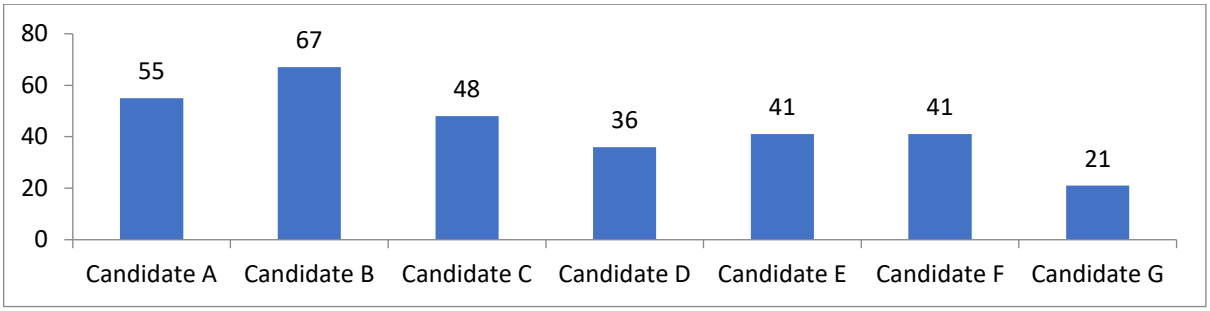

Figure 3: Percentage of instances when supportive moves (predominantly grounders) were used to modify requests by the trainees (candidates ordered by evaluation of their leadership – highest to lowest score)

The finding that successful team leaders use a high number of indirect and mitigated requesting strategies is significant in that it challenges theoretical claims put forward in the pragmatics (Brown and Levinson, 1987) and medical communication literature (Apker et al., 2005; Orasanu and Fischer, 2008), in which directness is equated with clarity and efficiency. The contrary seems to be observed from the communication patterns observed in the data here. In the context of these trauma simulations, in which teams perform time-pressured tasks, the use of indirect and mitigated requesting forms by high-performing trainee doctors did not decrease the team's efficiency and ability to carry out tasks quickly. Candidates A-D

all performed the required clinical tasks within the allotted 14 minutes, despite employing often lengthier and more time-consuming linguistic forms for making requests. The same phenomenon was often not observed in the case of trainees who relied more heavily on shorter, direct and unmitigated requesting strategies, particularly Candidate G, who fares worst overall. The success of employing more indirect, mitigated forms suggests a more collaborative enactment of leadership may be effective in the efficient completion of tasks, providing a counterargument to the claim that authoritative leadership styles facilitate more efficient communication, particularly in urgent contexts.

High-performing trainee

The previous section outlined general patterns across the data. Here we examine, in qualitative detail, the production and subsequent uptake from the delegation of tasks, both for high-performing trainees and for the trainee whose leadership was assessed less favourably. The extracts of the three simulations presented here exemplify some of the formulations identified above, within their immediate interactional and sequential context.
We first address a high-performing trainee doctor, Candidate A, who completed all of the key clinical tasks before the allotted time and was assessed positively by the other participants, with Linda and Jim, who play the roles of a nurse and a foundation doctor, stating in the debrief afterwards: 'Clear instructions in terms of leading me' (Jim) and 'Same. Really clear in terms of what he wanted me to do' (Linda). Candidate A's tendency towards minimising power asymmetries through the talk is visible from the start of the scenario, given in Extract 1 below. The opening moments of an interaction provide a crucial point for establishing rapport and the emerging negotiation of leadership in many settings (see Baxter 2015) and in ad hoc medical teams, where participants must introduce themselves and understand roles, they may be especially important.

Extract 1

Candidate A (Jason, 'CAN') is introduced to the medical team he is about to lead. The team consists of two healthcare professionals, Linda (nurse, 'NRS') and Jim (F2 doctor, 'F2D'). Linda provides Jason with information on the patient who is just about to arrive in the emergency department (ED) and, after this, Jason is given two minutes to prepare the station before the patient arrives. Real names of participants have been changed for anonymity. For transcription conventions, see Appendix.

```
33   NRS:  hi (.) hi are you the    [doctor in resus today    ]
34   CAN:                          [hi I'm Jason I'm the     ]
35   CAN:  A&E   [reg this evening               ]
36   NRS:        [yeah nice to meet you I'm      ] Linda
37   NRS:  I'm one of the nurses
38   CAN:  hello
39   F2D:   (.) I'm Jim one of the F2s
40   CAN:  hi Jim
41   NRS:  erm we've just had a ⁇red phone⁇ coming through
42   CAN:  yes
43   NRS:  erm ⁇the various details⁇ are up on the board
44   CAN:  [yeah  ]
45   NRS:  [erm   ] h- he's possibly been in an RTC
46   NRS:  he's been found next to a (.) a ⁇smashed⁇ car
47   NRS:  he's DEFINITELY got a head injury he's got low GCS
48   NRS:  and his - his      [BP's about ninety-sixty  ]
49   CAN:                     [okay (.) have we got a   ] trauma team here
50   NRS:  yeah do you want to give them a call
51   CAN:  can we put a trauma      [call out first please    ]
52   NRS:                           [alright okay             ]
53   CAN:  can you get IV access for me please
54   F2D:  yeah no worries
55   CAN:  (.) and then we can ⁇get some blood samples⁇
56   F2D:  blood samples
57   CAN:  er::h so IV access and all that- all that sort of stuff
58   F2D:  okay
59   CAN:  is that alright
60   F2D:  cool
[…]
105  CAN:  so as soon as they arrive Linda if you -
106  NRS:  yeah
107  CAN:  if we can get monitoring over   [here        ]
108  NRS:                                  [will yep    ]
109  CAN:  once we've had a handover
110  NRS:  [yep]
111  CAN:  [and] Jim as I say (.) if you're happy to do erm IV access
112  F2D:  no worries
113  CAN:  if he hasn't got his (.) erm (.) head immobilised can you do that
114  CAN:  first
115  F2D:  yeah  [yeah        ]
116  CAN:        [before      ] we get IV  [access      ]
117  F2D:                                  [okay        ]
118  PPP:  (0.7)
119  CAN:  until we've got him (.) secure is that alright
120  F2D:  yeah no worries
```

The extract demonstrates how Candidate A carefully balances task- and person-orientated aspects of the unfolding team interaction. Following the initial introduction of the participants and Linda's handover of the 'red phone' (a term used in UK emergency departments to refer to a call in from the ambulance service bringing in a severely ill patient) , the remaining two-minutes of preparation before the arrival of the patient is spent delegating specific tasks to the members of the team. In this opening interaction, two types of requesting strategies are used by the trainee doctor, both of them indirect. The first two requests for action, 'can we put a trauma call out first please' (line 51) and 'can you get IV access for me please […]' (lines 53-59), are both expressed through the means of a *query preparatory* formulation. This formulation entails the verbalisation of the request through the means of checking the other person's ability to perform an action and is often conventionalised in British English, identifying any potential obstacles as to why an action would not be performed (Gibbs, 1986). Through this checking of the other person's preparedness and ability to perform a particular task, the requesting strategy is closely concerned with enacting leadership in less coercive ways, allowing the other person to opt out of performing a given task. The reliance

on less coercive means of enacting the leadership role allocated to the trainee is also visible in the mitigation of requests uttered early on in the simulation. Such mitigation takes form of the use the plural pronoun 'we' (line 51), the politeness marker 'please' (lines 51 and 53) and the *appealer* 'is that alright' (line 59). The indirect nature of requests produced by the trainee is also visible later in the interaction, with Candidate A verbalising many requests as suggestions (*suggestory formulae* in the coding scheme). The use of these requesting forms is visible in lines 105, 107 and 109 ('if you- if we can get monitoring over here once we've had a handover'), and line 111 ('Jim as I say (.) if you're happy to do erm IV access'). In the case of the former, the false start and subsequent reformulation of what is being said, enables Jason to reword the request by replacing the singular personal pronoun 'you' with a plural one 'we', demonstrating the trainee's orientation towards mitigation of the force of the request by the emphasis placed on the shared team identity and consequently goals. The last request that is produced in Extract 1, 'if he hasn't got his (.) erm (.) head immobilised can you do that first before we get IV access until we've got him (.) secure is that alright' (lines 113, 115 and 118), is formulated using another query preparatory strategy. The request also provides an explanation as to the conditions under which the request should be carried out, expressed through the subordinate clauses 'if he hasn't got his (.) erm (.) head immobilised' and 'until we've got him (.) secure', and also *appealer* in the form of 'is that alright'.

Candidate A's use of more indirect and mitigated forms, as exemplified by the opening extract above, provides some insight into the more person-orientated aspects of the interaction then. Similar patterns, including high levels of indirectness and elaborated, mitigated forms of request, were observed for the other high-performing candidates, who were also positively evaluated by their teams. These high performing trainee doctors were also able to complete all of the key clinical tasks of the station within or faster than the allotted time, suggesting that longer, more mitigated indirect requests can be highly successful in a time-pressured team interaction, a finding considered in greater detail in the discussion section below.

Poor-performing trainee

Contrasted with the high-performing trainee above, the opening interactional sequence for Candidate G, a trainee doctor whose overall leadership performance is assessed considerably less favourably, is analysed in Extracts 2 and 3. We consider how his linguistic performance might highlights the communicative features of successful communication in the simulation.

Extract 2

Candidate G (Norbert, 'CAN') introduces himself to the team ('NRS' and 'F2D') before starting to delegate tasks.

```
32 CAN:  hello and you are↑
33 NRS:  Linda
34 CAN:  Linda (.) and you are↑
35 F2D:  I'm Simon ⌜I'm the⌝ F2
36 CAN:           ⌊Simon⌋
37       you are F2 ⌜Linda you are   ⌝
38 (ges): (points in Linda's direction)
39 NRS:             ⌊are you the regis-⌋ I'm a nurse- ⌜staff nurse ⌝
40 CAN:                                              ⌊and you are= ⌋
41       =the staff nurse
42 NRS:  nurse are you the reg in here today↑
43 CAN:  I am the reg here
44 NRS:  okay great have you heard about our red phone's coming in
45 CAN:  yes I have heard that erm (.) about this ⌜red come-      ⌝
46 NRS:                                          ⌊sixty year old=⌋
47       =chap ye:ah (.) maybe an RTC
48 CAN:  that's ⌜fine⌝
49 NRS:        ⌊head⌋ injury low GCS might need ⌜some ATLS⌝
50 CAN:                                         ⌊it looks like it's⌋
51       quite significant injury we need to organise our team
52 NRS:  ⌜okay ⌝
53 CAN:  ⌊okay↑⌋
```

The opening of Extract 2 begins in the same fashion as Extract 1, with members of the team introducing themselves before the trainee receives a handover from Linda summarising the 'red phone' case soon arriving. What is different about this interaction, however, is the interruption of this handover, lines 49-50. Before Linda finishes providing Norbert with the information all candidates would ordinarily receive, she is interrupted, with Norbert beginning to delegate tasks to the team. In line 51, we see a mitigated direct request, 'it looks like it's quite a significant injury we need to organise our team'. At the very start of the interaction the trainee doctor uses an *obligation statement* ('we need…'_) which contrasts with the *query preparatory* and *suggestory formulae* produced by high-performing trainee above. A pattern of greater use of direct requests is apparent throughout the interaction, as Extract 3 demonstrates.

Extract 3

The team is still waiting for the arrival of the patient.

```
62  CAN: okay so we need to put a trauma call out
63   (ges): (gestures in the direction of a whiteboard)
64  NRS: okay
65  CAN: okay we ⌜need an airway- yeah ⌝
66  NRS:         ⌊I'll go and do that  ⌋
67  CAN: put the trauma call out first
68   (ges): (follows Linda, initially has his back towards Stuart)
69  CAN: okay we organise our trolley (.) okay
70   (ges): (turns towards Stuart, gestures in his direction)
71  CAN: are you erh happy once the patient's come in
72  NRS: (speaking over the phone) hello trauma team to resus please
73  CAN: to quickly assess the airway
74   (ges): (points at himself)
75  CAN: okay (.) and give feedback to me↗
76  NRS: ⌜trauma call's out ⌝
77  CAN: ⌊okay↑             ⌋ (.) and sorry your name↗
78  NRS: Linda
79  CAN: Linda
```

Extract 3 contains a succession of *obligation statements*, 'we need to put a trauma call out' and 'we need an airway-', in lines 62 and 65. This is followed by another direct requesting strategy using an imperative, a *mood derivable,* 'put the trauma call out first', in line 67. It is only from line 71 that Candidate G starts producing a more indirect requests, asking 'are you happy once the patient's come in to quickly assess the airway okay (.) and give feedback to me'. The lack of any verbal or non-verbal response from the F2 doctor suggests however that it has not been received or fully understood. The greater use of direct and often unmitigated requests overall, perhaps highlights the trainee's less pronounced orientation to the interpersonal aspect of the interaction, with Candidate G also experiencing a troubled interactional moment when he forgets Linda's name (see line 77), which again may have implications for the establishment of the rapport.

3.5. Discussion of findings

Applying an adapted version of Blum-Kulka et al.'s (1989) CCSARP coding framework, we made a comparative analysis of trainee doctors' communicative performance in emergency medical training scenarios. This identified an association between greater use of indirect and mitigated delegation of tasks and the positive evaluation of their leadership skills. The initial coding was followed by a close analysis of the use of these formulations, demonstrating how successful doctors in the assessment paid greater communicative attention to balancing both person and task-related aspects of the ongoing team interaction.

It was not just the overall evaluations that were linked to these pragmalinguistic profiles. Trainee doctors who drew upon indirect and mitigated forms more frequently were also able to complete all or the majority of the key clinical tasks required for the scenario ahead of the station completion time, an observation that provides a counterargument to claims found in the pragmatics and health communication literature about linguistic directness as enabling greater clarity and efficiency. The indirect and mitigated forms did not lead to instances of misunderstanding and still allowed the doctors leading the teams to delegate tasks efficiently. Although simulated contexts do not hold the same contingencies as real trauma interactions, these interactions were nevertheless acutely time-sensitive. The observations made by us about rapport-building strategies not necessarily diminishing 'efficiency' then can arguably bear implications for other time pressured environments as well.

There are further contextual considerations not addressed by the analysis. It was notable that the types of mitigation practices which were evaluated more positively in this setting were those associated with the expression of deference and are also normatively associated with British English politeness – specifically politeness associated with the British middle classes (for discussion, see Mills, 2017). There is an argument to be made that such speech act forms can become highly conventionalised (Blum-Kulka, 1987, Leech 2014), meaning that performing actions through certain indirect and mitigated means might be understood more quickly by hearers in their cultural context. This warrants further investigation on the extent to which communicative norms in this setting are influenced by particular sociocultural norms and the extent to which this may put certain candidates at a disadvantage when

training and qualifying as a medical specialist. This would align with findings by Roberts et al. (2000) and Roberts et al. (2014), investigating the assessment of communication in medical education, in which pragmatic norms become tacit 'rules of the game' for assessment, with local speakers of British English better able to manage the requirements than those doctors whose first language was not English. Although we do not have data on the training backgrounds of doctors in the data, it is worth considering whether there may be a cultural dimension to their performances. This may be particularly pertinent when the less successful Candidate G *does* attempt to employ some indirect and mitigated formulations (such as 'are you happy once the patient's come in to quickly assess the airway okay (.) and give feedback to me' Extract 3, l.71-75), but does not deliver these in a form that are as quickly understood as the *query preparatory* and *suggestory formulae* that more successful candidates perform. Trainee doctors with a more tacit understanding of how to construct indirect and mitigated requests using the latter are likely to perform these more easily in the assessment. With further data, particularly evidence of the doctors training backgrounds and more examples of poor performing candidates, this is a feature we could explore using the pragmatic CCSARP coding framework. A pragmatic approach may therefore be of particular value in better understanding cultural dimensions of differential attainment in communicative performance in medical education.

Finally, it should be noted that, although the pragmatic framework identified a convincing pattern in the communicative performances of the trainee doctors, their performance is also likely to be multifactorial. The study shows important evidence for the value of certain types of indirect and mitigated requests in these team contexts, but other requirements such as the knowledge and confidence of the candidate in knowing the correct protocols, treatment plans and ultimately the right requests to make of staff are also crucial to effective performance. A pragmatic analytic approach can shed light on important aspects of communication then, but should not be understood as encompassing the full picture of a doctor's performance.

4. Conclusion

Early in this chapter, we fleshed out a definition of pragmatics as the study of meaning in real-world contexts, not concerned with abstracting fixed meaning from language but instead examining how the action performed by an utterance is bound up in its instance of use. Such an approach has particular value in making an evidence-based account of effective communication in healthcare. In the case study presented, it was through the lens of pragmatics that we were able to investigate communication in emergency medicine training, using a framework that coded linguistic forms of requests. The finding on the frequent use of indirect and mitigated forms challenged assumptions about their being less efficient or placing a high cognitive burden on the listener in emergency contexts. Studying situated language use in healthcare, incorporating pragmatic theories and concepts, can therefore have practical value in understanding communicative practices that are of relevance to practitioners but which otherwise remain hidden or only tacitly understood by speakers.

Nevertheless, pragmatics encounters certain limitations as a field. The sedimentation of different approaches and theories may account for its fragmentary applications in health

communication and elsewhere. Pragmatics is often speaker-centred and sentence-based, meaning that the focus of the analysis is also often firmly placed on particular speakers rather than all interactants engaging in a communicative event. This in turn can result in the analysis focusing on utterances or sentences, isolated from their immediate textual surrounding, meaning that an understanding of their uptake becomes omitted in the analysis. By combining pragmatic theories with, for example, discourse or conversation analytic approaches, as we have attempted in the case study, such limitations can perhaps be redressed. With the increasing number of studies that draw upon theories from pragmatics to inform linguistic analysis, applications to health communication are likely to grow. Pragmatics is well-equipped to enable analysts to gain insights with practical implications, providing a means for scaffolding a more interventionist analysis of health-related texts and talk, capable of addressing specific communicative issues as they are observed in real-world practice.

Acknowledgements

The authors are grateful to the editors and an anonymous peer reviewer for feedback on this chapter. This work was supported by the Economic and Social Research Council, Future Research Leaders grant [grant number ES/K00865X/1].

Appendix - transcription conventions

ges:	Gesture, described in brackets, for example: (nod)
PPP:	Pause indicated as a turn
(0.8)	Pause timed to tenth of a second
(.)	Pause of less than (0.2) seconds
·hhh	Inhalation
e::rm	Extended word/sound
bi-	Unfinished word/sound
↗	Rising intonation
↘	Falling intonation
→	Level intonation
??	Unsure of transcription
xxx	Inaudible sound
+≈	Speech latched to previous turn
⌈ ⌉ ⌊ ⌋	Half brackets indicate overlapping speech, for example: F2D: I'm Simon ⌈I'm the⌉ F 2 CAN: ⌊Simon⌋

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