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Patient-Directed Politeness Strategy Preferences in Clinical Visits Setting in Kuwait

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ABSTRACT

The vital context of Doctor–Patient communication is being abundantly researched to improve its outcomes. However, existing studies either focus on the doctor's perspective and pay little attention to the patient or focus on patients' satisfaction in relation to biomedical aspects, such as the doctors' clinical skills and the services provided in the healthcare institution. Research focusing on doctors' communicative skills provides a generalized discussion, under friendly attitude and communication style, lacking affiliation to a language-related theory. The current study investigates utterances produced by General Practitioner (GP) doctors in clinical visits in Kuwait, assessing the preferences of Kuwaiti patients in relation to three linguistic politeness strategies: direct, positive-politeness, and negative-politeness, as delineated in Brown and Levinson's infamous *Politeness Theory*. The current study further investigates the effect of sociolinguistic variables such as age and gender on patients' preferences. Overall, patients preferred negative-politeness in situations where the doctor instructs, proposes a referral visit, delivers potentially worrying news, or proposes changes to patient's care plan. In situations requiring medical advice or psychological support, the patients preferred positive-politeness. The direct approach was relatively least preferred.

Keywords: Doctor–Patient Communication; Politeness Strategies; Direct Strategies; Negative-Politeness Strategies; Positive-Politeness Strategies

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ARTICLE INFO

Received: 7 August 2024 | Revised: 3 September 2024 | Accepted: 9 September 2024 | Published Online: 15 November 2024
DOI: https://doi.org/10.30564/fls.v6i5.7010

CITATION

Alduaij, N., Almuoseb, A., Alsharhan, E., 2024. Patient-Directed Politeness Strategy Preferences in Clinical Visits Setting in Kuwait. Forum for Linguistic Studies. 6(5): 874–888. DOI: https://doi.org/10.30564/fls.v6i5.7010

1. Introduction

Among the numerous manifestations of interpersonal communication in institutions is that between doctors and their patients. Increased attention is being directed towards investigating the quality of Doctor–Patient (D–P) communication worldwide, owing to its effect on patients' compliance with the treatment plan [1–6] "Although the use of sophisticated technology may be employed for medical diagnosis and treatment, inter-personal communication is the primary tool by which the physician and the patient exchange information, and the adequate exchange of information may even improve patient's health…Thus effective communication between a doctor and his/her patients is indispensable for positive medical encounters and can be regarded as an essential prerequisite for optimal medical care" [3].

Effective communication should thus strike a balance between exchanging information successfully with the listener and maintaining a positive speaker–listener attitude. The current paper seeks to investigate how such balance can be achieved in D–P communication context. By focusing on a language variety rarely explored in this context, an Arabic variety, the current paper contributes an original outlook of some of the most common linguistic formulas in D–P communication context and their politeness value according to hearers, namely patients. The paper begins with defining the scope of doctor–patient (D–P) communication and how it is addressed in studies on the Arabic language. This is followed by a definition of linguistic politeness and its general manifestation in the Arabic language. The paper then reviews the application of Politeness Theory in D–P communication research and discusses how the current study contributes significantly to this underrepresented area of investigation. Next, the instrument is described, along with the data collection process and results. Finally, the discussion section is presented, followed by the limitations of the current study.

1.1. Doctor–Patient (D–P) Communication

To approach D–P communication from a linguistic perspective, we must first define its components. D–P communication entails two aspects or phases: information gathering, then explaining and planning[1]. The first aspect is often carried through sequenced question-answer, whereby the doctor asks questions about relevant symptoms and possible reasons and the patient provides answers or descriptions of the symptoms s/he is experiencing. In the second aspect, the doctor explains the diagnosis and possibly the outcome to the patient based on the detected symptoms, and decides the treatment plan accordingly, a process known as *decision-making* [1, 7–9].

The data for the present study focuses on the second phase, decision-making, which features communicative functions such as delivering news (favorable or unfavorable), clarifications, advice, suggestions, instructions, offering help or support, and so forth. The present study uses some of the most common linguistic constructs that General Practitioner (GP) doctors produced in clinical-visits' context from a previous study [10] and establishes the corresponding politeness-strategy type for each linguistic construct. It specifically investigates which politeness strategy is favored by each patients' group to deliver the doctor's target communicative function.

Doctor–Patient (D–P) Communication in Arabic

Following the global interest in improving D–P communication, a wealth of studies in the Arabian Peninsula set out to investigate patients' satisfaction with the health services in different facilities of the medical institution (such as public/private clinics or hospitals). [2] identifies some of the barriers to effective communication between family physicians and patients in walk-in medical centers in Dubai, UAE, one of which is the physicians' difficulty with rapport building. [11] assessed both clinical and communication skills of primary healthcare physicians as perceived by patients in Oman. Their patients demographic valued physicians' attempts of reassurance and relief of anxiety from illness as one of the key elements in effective D–P communication. [12] surveyed patients' opinion of their relationship with doctors in public hospitals in Qatar and found that physicians' communication skills (such as their ability to explain the medical problem properly, to treat patients with respect, and to relieve patients from illness-related worries) strongly cor-

[1]While these two phases suffice to encapsulate the communicative functions generally ongoing in D–P communication, it should be noted that other resources identify more detailed phases such as relational building, opening the discussion, gathering information, understanding the patient's viewpoint, sharing information, reaching an agreement/counseling, and terminating the consultation usually by the doctor [7, 8].

related with increased patients' satisfaction. In Kuwait,[13] included communication skills as one of the factors determining patients' satisfaction with primary healthcare centers services in Kuwait City but do not specify what such communication skills entail. In another study on Kuwaiti patients,[14] investigated barriers that discourage medication taking in diabetic patients and recognized physicians' communicative attitudes, such as paternalism and lack of compassion with the patients, as one of those barriers.

Other studies include[7], who explored the factors that hinder effective verbal and non-verbal communication between doctors and patients, and further investigated the effect of sociolinguistic variables such as patient's gender and level of education on the quality of D–P communication in clinical consultations in Jordan.[15] assessed the relationship between primary care physicians and patients in Arabic and identifies seven aspects of patient satisfaction, two of which focus on interactional aspects: interpersonal manner and communication. Evident from the aforementioned review, the bulk of existing studies on D–P communication in Arabic touch upon the topic of communication style of doctors, such the degree of friendliness or empathy, but do not target the exact verbal (linguistic) strategies being used by the doctors and how the patients react to these strategies.

1.2. Politeness Theory

The notion of politeness in general refers to socially correct or appropriate speech and behavior. In other words, it entails verbal and non-verbal behavior that attends to the feelings and expectations of the other interlocutor(s) with whom one is speaking. Manifestable in various forms, politeness is a universal concept that is present in every culture, language, and social interaction[16].

Theorized by Brown and Levinson[17], Politeness Theory evolves around the concept of *face,* established by Goffman[18] a social perception of self that every individual has and expects others to observe and consider throughout interactions. Face has two simultaneous requirements, recognized as needs or wants. *Positive face* refers to the individual's desire to be approved of and appreciated by other members of the interacting group. *Negative face* refers to the individual's desire to be unimposed upon and maintain autonomy in thought and action. Much of the rationale behind speakers' linguistic choices in speech lies within understanding face needs. Seeking to preserve their own face in interaction, speakers are careful not to compromise the face of the hearer: "Without facework, talk would probably be extremely direct, specific, fast and impersonal"[19].

Most of the communicative functions that language users produce regularly, such as interrupting, criticizing, disagreeing, requesting information or actions, suggesting, warning, instructing, and so forth as, infringes on either face need of the recipient (positive or negative), to various degrees. These speech acts are therefore termed *Face-Threatening Acts* (FTAs)[19–21]. A request or advice, for instance, threatens the listener's negative face by imposing upon his/her need for freedom from imposition, whereas a disagreement or a refusal threatens the listener's positive face. Politeness, in Brown and Levinson's view, caters to face needs, and is recognized as strategies of redressive action people engage in to preserve positive face or mitigate threats to negative face.

Accordingly, linguistic strategies that appeal to positive face wants are recognized as *positive politeness.* Positive-politeness strategies include, for instance, the use of colloquial or slang language to convey in-group membership, the use of inclusive forms such as '*we*' or '*let's*' that include both speaker and listener in the activity, the use of ellipsis (omission) to communicate tacit understandings: '[Do you] *mind if I used your phone*?', the use of first names, nicknames, or in-group names to insinuate familiarity: '*Hey buddy*, have you got a minute?', claiming common point of view that asserts speakers' knowledge of listener's wants: 'You know how the teacher does not like it when we ask for extension', giving reasons that justify the desired activity to the listener: '*I'm really late for an important appointment, so..*', showing interest in listener's qualities or acknowledging listener's needs, and asserting reciprocal exchange: '*Do me this favor, and I'll make it up to you*'[20]. In D–P communication, linguistic techniques that communicate reassurance, understanding, empathy, encouragement, interest, and cooperation with the patient all fall under positive politeness strategies[1, 22].

On the other hand, those strategies that appeal to negative-face needs are recognized as *negative politeness*. Negative-politeness strategies include, for instance, the use of indirect questions to enquire about listener's ability or willingness to comply: '*Can/Will you do X?*', the use of hedges or words/phrases which minimize the imposition: 'I

need *just a little* of your time', the use of address terms or honorifics and other formal language choices that show difference and establish social distance, the use of apologies that acknowledge the imposition: '*I'm sorry to bother you*, but..', the use of passive or other forms that impersonalize the speaker and listener: *'Is it possible to request a favor?*', and the use of past tense to create distance in time: '*I had been wondering if I could ask you to X*'[20].

Brown and Levinson postulate the possible ways of performing an FTA in a five-leveled hierarchy from most to least direct, illustrated in **Table 1**. The most direct strategy is *bald on record* when the speaker expresses the intended message directly without redressive action. Alternatively, employing redressive action when performing the FTA can take either direction: attending to listener's positive face (hence *positive-politeness* strategy) or negative face (hence *negative-politeness* strategy). The fourth strategy is *off-record* where the speaker merely refers to some relevant condition and leaves the deduction of the intended message to the listener. This strategy not only decreases the imposition to the listener's negative face, but also shields the speaker's positive face from having to deal with unpreferable responses to the FTA[2]. The fifth strategy is not performing the FTA at all which bears zero threat to face and thus maximum politeness. For example, in situations where the speaker is able to perform the requested action themselves with some extra effort, it is best not to ask the listener for help in the first place. When speakers perform an FTA, they choose from one of the abovementioned five strategies based on their assessments of three social and context-dependent factors: P (perceived social power of hearer relative to speaker), D (social distance between speaker and hearer), and R (rating of imposition or threateningness of an utterance judging by social and cultural norms). As such, the use of bald on record is more appropriate for lower-level face-threat and negative-politeness strategy for higher-level face-threat[16]. The focus in the current study is on strategies (1) bald on record, i.e., direct, (2) positive politeness, and (3) negative politeness.

While the theory provides a systematic conceptualization of the notion of politeness and its linguistic applications, the outlining of politeness strategies in Brown and Levinson's theory was based mainly on data from three languages: English, Tamil, and Tzeltal. These patterns may not be applicable to speakers in other communities such as Arab and Islamic, Asian, and African where the concept of face is more intricate than the individualistic definition described in the theory[23]. For example, religious grounding plays a substantial role in establishing the concept of face among Arabs and Muslims. Traits such as consideration, compassion, and graciousness are strongly promoted in Islamic teachings[24]. The current study therefore aims to contribute a more informed Arabic-oriented understanding of politeness based on empirical data. The institutional D–P communicative context explored in the current study is equally underrepresented in politeness literature.

Politeness Theory in the Arabic Culture

Though politeness is a universal phenomenon, each language bears its own stylistic devices for expressing politeness. These devices include for instance phonological features, morphological features such as lexical choices and word endings, and syntactic features such as the use of direct/indirect constructions, the use of phrases that mark speaker's hesitation and the like. Arabic is considered among the richest languages when expressing politeness as it offers a variety of such linguistic devices[25]. Samarah[26] argues that politeness in Arabic is rooted in two pillars: religion and social conventions, and they both require an individual to strike a balance between humility and dignity when communicating with others. When considering the speech act of requesting, for instance, the humble way is to use forms that show respect and appreciation to listener's space (i.e., negative politeness) such as [*mumkin law samaht tsalifni flws*] '*Would you please lend me some money?*'. On the other hand, the dignified way is to use the bald on record strategy such as [*sallifni flws*] '*lend me some money*' which operates on solidarity between speaker and listener. In fact, the bluntness of the imperative is often softened in Arabic by adding fixed religious expressions of listener-directed well-wishes such as [*Allāh yikhallīk*] '*May God spare you*' in Kuwaiti Arabic. Such Islamic prayers are regularly used in Arabic as substitution to the modality system in English with a similar mitigating effect[27, 28]. Samarah further outlines ten semantic categories when identifying politeness in Arabic language. Some of his categories correspond to negative

[2]Off-record strategy highly depends on an interactive physical context where interactants can process such FTAs without verbalization of the speaker's intended message and is therefore overlooked in the current study.

Table 1. Brown and Levinson's five super-strategies for performing FTA.

Directness Level ↑ Increasing / Politeness Value ↓ Decreasing	Super-Strategies	
	(1)	Bald on record
	On record; Performing FTA with redressive action	**(2)** Positive Politeness
		(3) Negative Politeness
	(4)	Off-record
	(5)	Not performing FTA

politeness such as permission, respect, and recognition of social status via pronouns and address terms, while other categories reflect positive-politeness strategies such as sociability, benevolence, hospitability, and generosity. It goes without saying that speakers vary their choice of politeness strategy according to the ongoing sociocultural factors such as age, social status, and gender of the addressee.

It is often contended in the literature on linguistic politeness that Arab speakers lean more towards linguistic strategies that mark intimacy between the interlocutors, while individuals in the Western cultures recur to negative-politeness strategies. For example, El Mourad [25] argues that French and English speakers opt for linguistic devices that increase the social distance between speaker and hearer. Najeeb et al. [23] also found that the most used politeness strategy across the emails of Arab postgraduate students when communicating with their academic supervisors was positive-politeness strategy. Other studies yielded findings that challenge the proposed symmetric relation between directness and politeness outlines earlier (Section 1.2). Alsoraihi [28] and Tawalbeh and Al-Oqaily [29], for instance, found that their Saudi participants resorted to directness more often than their American counterparts to mark social closeness and group-connectedness between speaker and listener, rather than impoliteness. In this respect, Kerkam [30] argues against such stereotypical associations of politeness with indirectness. Rather, perceptions of politeness are largely determined by sociocultural conventions and context rather than absolute linguistic (in)directness.

1.3. Politeness Theory in Doctor–Patient Communication

A few studies set out to investigate the politeness strategies used in D–P communication and the effect of sociocultural variables such as patients' gender, age, social class, educational level on the strategies employed. For example, Ng et al. [21] conducted a pilot study on politeness strategies used between doctor and patient in a private clinic in Kuala Lumpur. The researchers used 30 audio recordings of medical consultations between two doctors and 30 consented Malaysian citizens aged 18 years and above. The most used politeness strategy in their data by both doctors and patients was bald-on-record direct strategy, followed by negative politeness, then positive politeness.

Zibande and Pamukoğlu [6] investigated the use of politeness strategies by a Turkish radiologist doctor when addressing female and male patients in relation to two age groups: patient is older than the doctor vs. patient is younger than the doctor. Using audio-recorded data, they found a combined effect of patients' gender and age on the doctor's use of politeness strategies. For example, the doctor used more positive-politeness strategies when interacting with the younger female patients and more negative-politeness strategies when addressing the older female patients. When addressing the younger male patients, the doctor relied exclusively on the most direct bald-on-record strategy.

Lodhi et al. [4] also found an effect of age in their audio-recorded data of Doctor–Patient discourse in different government hospitals in Pakistan. The doctors in their sample used more negative-politeness strategies, mostly via the use of addressing expressions that mark respect, when interacting with female patients who are younger than the doctor. Conversely, the doctors were more direct when addressing younger male patients. They employed a positive-politeness strategy by using informal 'men-talk' as means to minimize the distance between the doctor and the patient. Lodhi et al. [4] further found differences between male and female patients in their evaluation of the communication with the doctors. For example, female patients agreed that their doctors informed them about their present physical health condition more than male patients who mostly disagreed.

In the current study, we seek to investigate the extent to which variables such as age and gender of the patient, on the one hand, and the doctor, on the other, affects participants (patients) politeness-strategy preference.

2. Method

2.1. The Instrument: Multiple Choice (MC) Questionnaire

The questionnaire for the current study is designed to assess linguistic preferences of Kuwaiti Arab patients in six Doctor–Patient communication scenarios. The scenarios are based on a previous study by the authors [10], where 26 GP doctors at three family medicine healthcare centers at Al-Assimah Governate were asked to provide written responses on what they would say to their patients in a similar real-life situation. The six scenarios provided target a range of some of the most common communicative functions that GP doctors encounter in clinical visits such as instructing the patient, advising the patient, examining a reluctant patient, delivering bad test result to the patient, referring the patient for a future visit, and supporting an apprehensive patient, as depicted in **Table 2**.

The doctors' responses were categorized according to their syntactic and pragmatic features into function-based strategies, identifying percentages of usage. Examples of the most used patient-directed linguistic strategies from our previous study data are selected for MC questionnaire in the current study. Some of the selected utterances represent a more direct strategy to delivering the target speech act, while others illustrate positive- or negative-politeness strategies. The participants in the current study have no clue as to the politeness orientation of each strategy provided in the MC questionnaire but were instructed to select the choice they prefer to be addressed with by their doctor if they encounter a similar situation.

Other information obtained from the participants via the MC questionnaire include age, gender, educational background, frequency of visiting the clinic in the past three months, and nationality of the attending GP doctor. These represent some possible variables that could affect patients' preferences of certain linguistic strategies. While individual differences play an inevitable role on speakers' preferences, obtaining data from larger numbers of participants should help reveal a pattern that is somewhat generalizable to the larger population of native speakers. In this respect, Leech [31] testifies to the validity of using MC questionnaires in rating pragma-linguistic politeness, that is the politeness value of utterances taken out of context (context-invariant).

Categorizing the Linguistic Strategies in the MC Questionnaire into the Three Politeness Types: Direct, Positive Politeness, or Negative Politeness

The linguistic strategies from each of the six scenarios in the MC questionnaire for the current study were categorized into three types: direct strategy, positive-politeness strategy, and negative-politeness strategy. It should be noted that doctors' responses in the original study [10] did not represent all three strategy types equally. Some doctors' responses were slightly amended so that the three strategy types are equally distributed across each of the six scenarios in the current study. The following section explains the rationale for placing each linguistic strategy under the corresponding politeness type.

In scenario-1, the strategy '*I need you to do X*' projects the requested act as some necessity that needs to be met. It orients more to positive-politeness strategies, assuming that once the speaker states his/her need, the listener is somewhat compelled to attend to it by means of cooperation and benevolence. Possibility questions as in '*Is it possible that you do X?*' are classic examples of negative-politeness strategies. By using a yes/no question that could be answered with no if the listener is not able to perform the requested act at the time, this strategy clearly acknowledges listener's autonomy. The direct strategy to perform a request would be the imperative '*Do X*.' This strategy was added to the choices in the current study's questionnaire as it did not occur in the original data of doctors' responses.

In scenario-2, the passive statement represents a negative-politeness strategy. The use of passive when advising poses minimal imposition upon listener's freedom of action, and they are given maximum liberty not to comply with the advice which is presented as some general fact for everyone (see Morand [20]). 'Suggestory Form' formulated using the interrogative phrase *ʃra:j-ik* '*What do you think?*' is conventionally used in KA for performing advice/suggestions. Interrogatives ideally acknowledge the listener's right to autonomy by allowing them to accept or dismiss the

Table 2. The context of the six scenarios in the instrument.

Situational Prompt	The Communicative Function Elicited (Speech Act)
Scenario-1	Instructing the patient
Scenario-2	Advising the patient
Scenario-3	Examining the reluctant patient
Scenario-4	Delivering bad test result to the patient
Scenario-5	Referring the patient for a future visit
Scenario-6	Supporting the apprehensive patient

suggested act. Despite its interrogative form, *ʃra:j-ik* is commonly used in informal contexts between socially connected participants and is therefore grouped as a positive-politeness strategy. 'Obligation Statement', on the other hand, is more binding and intrusive. The listener is not given any freedom for not complying with the advice stemming from speaker's responsibility towards maintaining the listener's wellbeing. 'Obligation Statement' thus represents a direct strategy because it uses the deontic modal participle in KA *la:zim* '*it is obligatory*'.

In scenario-3, 'Showing Empathy' clearly illustrates a positive-politeness strategy, while 'Seeking Patient's Consent' via the form '*Do you mind if I do X?*' represents a negative-politeness strategy because it emphasizes the listener's freedom of choice. On the other hand, proposing the action in the form of '*I will do X'* is grouped as a direct strategy because it leaves minimal freedom of choice for the hearer.

In scenario-4, 'Showing Empathy' also illustrates a positive-politeness strategy. Proposing the treatment plan in the form of '*I want you to do X'* is deemed a direct strategy. 'Explaining the Predicament' is least intrusive as it provides the listener with the relevant input and letting them decide how to act next. This strategy is hence grouped under negative politeness.

In scenario-5, 'Commitment Statement' '*I will do X*' represents a direct strategy. The speaker uses the future indicator in KA *ra:ħ* and commits him/her-self as well as the listener with the stated future action. 'Suggestory Question' employs the conventional KA suggestion/advice indicator *ʃra:j-ik* used for informal contexts (see scenario-2) and is therefore grouped under positive politeness. The interrogative '*If you could do X?*' seeks patient's consent regarding the proposed action and thus represents a negative-politeness strategy.

In scenario-6, 'Statement of Reassurance' represents a positive-politeness strategy. By showing concern to the listener's psychological state, the speaker is prioritizing the element of solidarity. 'Advice' is considered a direct strategy because the speaker is specifically directing the listener on how to act in this situation. The interrogative, on the other hand, seems representative of negative politeness because the speaker is not imposing an action on the listener per se. Rather, the speaker is allowing the listener to redirect their perceptional orientation based on the medical data that the doctor is presenting objectively.

The **Table 3** below enlists all the utterances used in the MC questionnaire in Kuwaiti Arabic, with transliteration and English translation, and specifies the politeness-strategy type for each utterance.

Table 3. The three politeness strategies used for each scenario in the MC questionnaire, with transliteration and English translation.

Scenario	Politeness Strategy	Utterance as Provided in the MC Questionnaire
1	Direct	روح ورا الستارة عشان افحصك *'Go behind the curtain so I (can) examine you?'* rūḥ warā al-sitāra ʿashān afḥaiṣik[1]
	Positive	أبي أفحصك ورا الستارة *'I want to examine you behind the curtain.'* 'abī afḥaṣak warā' al-sitāra
	Negative	ممكن تروح ورا الستارة عشان أفحصك؟ *'Is it possible for you to go behind the curtain, so I (can) examine you?'* mumkin turūḥ warā al-sitāra ʿashān afḥiṣik?

Table 3. *Cont.*

Scenario	Politeness Strategy	Utterance as Provided in the MC Questionnaire
2	Direct	لازم تلتزم بالحمية الغذائية. *'You must follow a diet'* lāzim tiltizim bi-al-ḥimya al-ghidhāʾiyya
	Positive	شرايك نبدي نظام غذائي عشان يساعدنا؟ *'What do you think of (us) starting a diet so it can help us?'* shrāyik nibdī niẓām ghidhāʾī ʿashān ysāʿidnā?
	Negative	العلاج يحتاج إلى تعديل في النظام الغذائي. *'The treatment requires a change in the diet system.'* al-ʿilāj yiḥtāj ilā taʿdīl fī al-niẓām al-ghidhāʾī
3	Direct	دكتورك اليوم مو موجود وانا راح أشوفك بداله. *'Your doctor is not available, and I will see you instead.'* duktūrik al-yawm mō mawjūd wa-ānā rāḥ ashūfik bidālah
	Positive	شكلك متضايق من اللي حصل وآنا مالومك. *'You seem upset regarding what happened, and I do not blame you.'* shaklik mitḍāyiq min al-li ḥaṣal wa-ānā mālūmik
	Negative	هل عندك مانع اشوفك بدال دكتورك؟ *'Do you mind if I see you today instead of your doctor?'* hal ʿindik mānīʿ ashūfak bidāl duktūrik?
4	Direct	أبيك تمشي معاي خطوه بخطوه بالعلاج. *'I want you to follow my lead/instructions step by step regarding the treatment.'* ʾabīk tamshī maʿāy khuṭwa bi-khuṭwa bi-al-ʿilāj
	Positive	آنا شايف إنك قاعد تحاتي ومقدر هالشي. *'I see that you are worried, and I understand your concern.'* ānā shāyif innik gāʿid taḥātī wa-mqaddir hāsh-shay
	Negative	عندك نتيجة هالتحليل مرتفع لكن ممكن إحنا نسيطر عليه بالأدوية والعلاج. *'This test result of yours is high but we can control it with proper treatment and medication.'* ʿindik natījat hā-at-taḥlīl murtafiʿ lākin mumkin iḥnā nsayṭir ʿalayh bi-al-adwiya wa-al-ʿilāj
5	Direct	راح احتاج أقعد معاك زياده بموعد ثاني نتناقش بالموضوع. *'I will need to sit with you in another appointment to discuss this matter.'* rāḥ aḥtāj aqʿad maʿāk ziyāda bi-mawʿid thānī nitnāqash bi-al-mawḍūʿ
	Positive	شرايك تأخذ أقرب موعد معاي عشان نتناقش أكثر بالموضوع؟ *'What do you think of (you)-taking the nearest appointment with me so we can discuss this matter further?'* shrāyik taʾkhidh aqrab mawʿid maʿāy ʿashān nitnāqash akthar bi-al-mawḍūʿ?
	Negative	إذا ممكن تأخذ موعد ثاني معاي بأقرب فرصة عشان نتناقش أكثر بالموضوع؟ *'If it's possible for you to schedule another appointment with me soon so we (can) discuss this matter further.'* idhā mumkin taʾkhidh mawʿid thānī maʿāy bi-aqrab furṣa ʿashān nitnāqash akthar bi-al-mawḍūʿ
6	Direct	اللي تفكر فيه غلط ومافي إلا العافيه وهذا القلق مضر لك أكثر من نفعه. *'What you are thinking of is wrong, and overthinking would do you more harm than good.'* al-li tfakkir fīh ghalaṭ wa-māfī illā al-ʿāfiya wa-hādhā al-qalaq muḍir lik akthar min nafʿah
	Positive	أطمنك أن أنت ماعندك أي مرض خطير وكل الفحوصات تأكد هالشي فماله داعي تخاف ولا تفكر بزياده. *'I assure you that you do not have a serious illness and all the test results confirm that so there is no need for you to worry or overthink about it.'* aṭamnik ann anta māʿindak ayy maraḍ khaṭīr wa-kill al-fuḥūṣāt tuʾakkid hāsh-shay fa-mālah dāʿī tikhāf wa-lā tfakkir bi-ziyāda
	Negative	شنو اللي خلاك تفكر بهالمرض؟ حسب التاريخ المرضي اللي ذكرته لي التشخيص كلش ما يمشي مع مخاوفك *'Why would you think of this disease? According to your medical record, the symptoms and diagnosis are completely inconsistent with the disease you are thinking of.'* shinu al-li khallāk tfakkir bi-hā-al-maraḍ? ḥasab al-tārīkh al-maraḍī al-li dhakartah lī al-tashkhīṣ killish mā yamshī maʿa makhawifik

This research utilises the Cambridge transliteration scheme for all Arabic examples presented throughout the study. For a detailed explanation of this transliteration system, refer to Badawi, Carter, and Gully [32].

2.2. Data Collection

Prior to administering the MC questionnaire, a pilot questionnaire was administered to 20 participants, 4 males and 16 females. The pilot questionnaire included the same six scenarios with an additional seventh scenario (scenario-2-B) concerning the use of '*you*' vs. '*we*' when using the same advice statement presented to the patient in scenario-

2-A. This additional scenario was removed from the MC questionnaire as a few participants reported in their verbal feedback that they found this question somewhat confusing. The average time for completing the pilot questionnaire was 5 minutes.

The data was collected via MC questionnaire from Kuwaiti participants affiliated to government primary healthcare centers across Al-Assimah (the capital) governate in Kuwait. The patients who go to these centers to seek medical help in non-emergency situations are usually residents of those areas[3]. The second author collected the data in person at two "Family Medicine" centers (Al-Yarmouk and Al-Adaliya) by asking patients to fill in the questionnaire via her laptop immediately after they have finished their consultation visit with the GP. This practice was meant to ensure the patient would provide fresh feedback from their recent encounter with the GP. However, the participation rate was disappointingly low; only 29 participants agreed to take part within the first week of data collection. Therefore, the authors opted for circulating the questionnaire electronically among potential participants, following the data collection norm in Kuwait in recent years. This practice proved much more effective as the total number of participants reached 848: 215 males and 633 females.

Three age groups were included in the questionnaire as follows: 20–39, 40–59, and 60+ years old, and most of our participants are from the second 'middle-aged' group. When inquired about the educational level, the majority of our sample (around 77%) are graduates, and most participants reported that their average for visiting the healthcare center was once a month over the last three months. The dominance of female participants was also reported in another aspect of the questionnaire. When asked about the gender of the GP doctor when they visit the healthcare center, most participants (59%) reported that the doctor was female. Naturally, healthcare centers in Kuwait employ both Kuwaiti and non-Kuwaiti GP doctors to meet the public's needs for doctors in the sector (Al-Duwaisan[4], 2023), but Kuwaiti doctors represent a higher portion. This was confirmed by our participants answers, where around 58% reported that the doctor they see when visiting the healthcare center is oftentimes Kuwaiti.

Research Questions

The current study seeks to answer the following research questions:

1. To what extent do Kuwaiti patients prefer each of the three politeness strategy types: negative politeness, positive politeness, or direct strategies when being addressed by Kuwaiti doctors?
2. What is the effect of patient's gender and age in the preference of communication strategies among Kuwaitis patients when being addressed by the GP?
3. What is the effect of doctor's gender and age in Kuwaiti patients' preference of communication strategies when being addressed by the GP?

3. Results

The preferences for communication styles between male and female patients in various medical scenarios demonstrate that both groups exhibit distinct preferences depending on the specific context of the interaction. This section reviews the results in detail, providing a comprehensive analysis of how male and female patients prefer to be communicated with by their doctors across different medical situations. Each scenario reveals unique insights into the preferred communication strategies, highlighting the nuanced ways in which patients wish to receive medical information, advice, and emotional support, depending on the scenario's nature and the relational dynamics involved, namely the doctor's gender and age.

3.1. Female Participants

In scenario-1, wherein the doctor instructs the patient for examination, female participants strongly preferred the negative-politeness strategy in interrogative form bearing the conventional possibility particle *mumkin* with both female and male doctors. Female participants did not prefer the imperative structure of the direct strategy nor the positive

[3]Prospective patients also include non-Kuwaitis such as the domestic help working at Kuwaiti families' households or tenants living at the same area. Non-Kuwaiti patients are not the subject of this paper.

[4]The authors conducted a private interview (recorded via TEAMS) with the Head of Kuwaiti Association of Family and General Practitioners (Dr. Huda Al-Duwaisan), on Dec. 11th, 2023, to obtain accurate information on the language setting in healthcare clinics and current communication-skills training programmes for GP doctors in Kuwait.

politeness strategy, with less than 7% selection rate.

In scenario-2, wherein the doctor advises the patient on dietary change, more than 55% of female participants preferred to receive the medical advice via the positive-politeness strategy bearing the conventional and informal advice indicator *ʃra:j-ik* with both female and male doctors. More than one third of female participants (33-37.6%) preferred to receive the medical advice using the negative-politeness strategy. By contrast, the direct strategy which employs the deontic modal participial *la:zim* was least preferred by female participants (less than 8% selection rate), as it is the most invasive and leaves no room for the listener but to comply with the advice topic.

In scenario-3, wherein the doctor examines a reluctant patient, around 72% of female participants preferred the negative-politeness strategy whereby the doctor seeks the patient's consent prior to proceeding with the course of action. Female participants did not seem to value an expression of empathy in this scenario and the positive-politeness strategy received a selection rate of less than 3% with both female and male doctors. A significant proportion of female participants (around 26%) preferred the direct strategy whereby the doctor plainly describes the situation and the consequent course of action.

In scenario-4, wherein the doctor delivers bad tests results to the patient, female participants mostly preferred the negative-politeness strategy with both female and male doctors (almost 74%). The doctor here describes the medical situation and highlights that it is manageable with proper action, which does not pressure the patient while receiving potentially worrying news. Almost one quarter of female participants (20%–22%) selected the direct strategy where the doctor straightforwardly instructs the patient on the ensuing course of action. Very few female participants selected the positive-politeness strategy where the doctor simply expresses empathy towards the patient's concerns.

In scenario-5, wherein the patient's time has finished but the consultation needs further discussion, female participants preferred the negative-politeness strategy in conditional interrogative structure with both female and male doctors. A considerable portion of female participants (between 28%–30%) preferred the positive-politeness and the direct strategy to somewhat equal extents. In the direct strategy, the doctor commits the patient to coming for another visit using the future indicator in KA *ra:ħ*. In the positive-politeness strategy, the doctor proposes the action as an informal suggestion using the conventional suggestion/advice indicator *ʃra:j-ik*. In scenario-6, wherein the doctor is expected to support an apprehensive patient, most female participants preferred the positive-politeness strategy with both female and male doctors. The doctor here explicitly (using a performative verb '*I assure*') reassures the patient and further dismisses their fear by referring to trustworthy medical data. The direct and the negative-politeness strategy were least preferred by female participants, with a selection rate of less than 15%. In the former, the doctor directs and advises the patient not to worry, while in the latter the doctor uses the interrogative form to logically lead the patient to dismissing their unjustified fear.

Looking at the doctor's age variable, female participants preferred either negative-politeness or positive-politeness strategies when dealing with doctors younger than themselves depending on the context of the scenario. In contexts where the patient would value deference to a larger extent (such as scenarios 1, 3, 4, and 5), female participants leaned more towards negative-politeness strategies. Conversely, female patients preferred positive-politeness strategies when being advised (scenario-2) or when being supported psychologically (scenario-6) by the younger doctor. **Figure 1** below illustrates female participants politeness-strategy preference percentage when being addressed by female doctor Vs. male doctor in each situation.

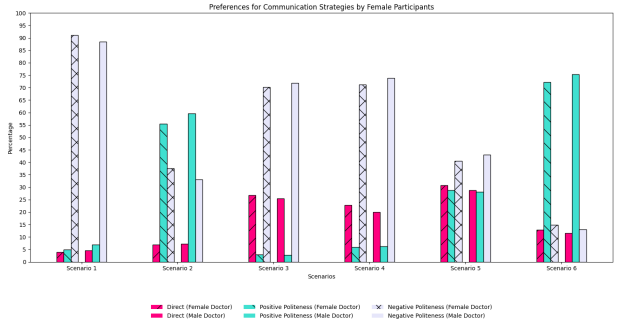

Figure 1. The frequency of using each politeness strategy (Direct, Positive-Politeness, Negative-Politeness) in each situation by female participants when being addressed by female Vs. male doctor.

3.2. Male Participants

In scenario-1, male participants also preferred the negative-politeness strategy, with both female and male doc-

tors, and did not prefer the direct strategy. The positive-politeness strategy was not preferred by male participants either, though slightly more male participants opted for this strategy when dealing with female doctors than did the female participants (13.33% vs. 6.92%). In scenario-2, the most preferred strategy by male participants was negative politeness with female doctors, and positive politeness with male doctors. Qari[27] found a similar gender-related difference in politeness strategies selected for performing the speech act of apologizing across Saudi participants. Saudi females used more positive-politeness strategies when apologizing to their fathers compared to Saudi males who preferred more negative-politeness strategies. In scenario-3, male participants showed a strong preference for the negative-politeness strategy with both female and male doctors and did not prefer the positive-politeness strategy. Almost one-third of male participants preferred the direct strategy particularly with female doctors (37.7% vs. 28.8% with male doctors). In scenario-4, the negative-politeness strategy was the top choice for male participants, particularly with same-gender doctors (81.58% with male doctors vs. 73.33% with female doctors). Male participants, like female participants, did not value the positive-politeness strategy in this situation. The direct strategy was preferred by some male participants (almost 17%), though to a lesser extent compared to their female counterparts. In scenario-5, male participants preferred the direct strategy with female doctors and the negative-politeness strategy with male doctors. Almost 21% of male participants selected the positive-politeness strategy. In scenario-6, the positive-politeness strategy was the main preference with both female and male doctors. Similar to results from female participants, the direct and the negative-politeness strategy were least preferred by male participants.

Looking at the doctor's age variable, male participants preferred negative politeness when dealing with doctors younger than themselves in scenarios 1, 3, and 4, and positive politeness in scenario 6. Male participants demonstrated equal preferences for both negative- and positive-politeness strategies in scenario 5. Similarly, the difference in the selection rate between negative- and positive-politeness strategies in scenario 2 was rather marginal. **Figure 2** below illustrates male participants politeness-strategy preference percentage when being addressed by female doctor Vs. male doctor in each situation.

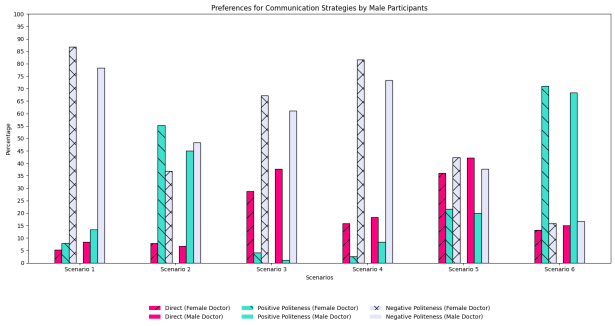

Figure 2. The frequency of using each politeness strategy (Direct, Positive-Politeness, Negative-Politeness) in each situation by female participants when being addressed by female Vs. male doctor.

4. Discussion

Both female and male patients predominantly preferred to be instructed in medical setting using the conventionally indirect form of negative politeness *mumkin 'Is it possible for you to do X?'*. Negative politeness here communicates more respect in comparison to the direct strategy which sounds overtly authoritative, particularly when used without mitigating phrases such as prayers of good wishes that conventionally minimize the imposition in Kuwaiti and many varieties of Arabic. This finding could further be explained considering the age of the doctor relevant to the patient. Around 60% of the participants in our sample reported that oftentimes the doctor they see would be younger than them. Though the doctor holds institutional power in the medical institution, the age factor still has a considerable impact on the linguistic choices of society members. It is very likely that the participants have been addressed using a similar negative-politeness linguistic structure in a similar clinical visit situation, particularly by younger doctors.

In the situation involving a medical advice, most female participants opted for a positive-politeness strategy. Given that the doctors whom our participants encounter at clinical visits are mostly females, positive politeness is preferred as it communicates in-group solidarity between same-gender members. Interestingly, the preference for positive politeness in giving medical advice was also observed in doctors' responses in the original study[10]. Many doctors used the informal suggestory form with inclusive '*we*' rather than '*you*' when advising the patient. Gender seems to influence not only the linguistic formulation of the advice but also how it is received by the patient. Schieber et al.[9] found that French patients agreed more with their doctors on advice concerning

their nutrition, weight loss, and physical activity in gender concordance (same-gender) communicative situations than in gender discordance situations. The effect of gender in the current study was more significant in male participants' choices who preferred positive politeness with male doctors and negative politeness with female doctors. This finding further emphasizes the need for greater deference when interacting with members of the opposite gender. Apart from gender effect, a positive-politeness strategy could be preferred as it projects the advice as a less serious issue, giving the hearer a greater sense of optionality. The negative-politeness strategy was also valued when giving a medical advice as the passive form poses minimal imposition upon hearer compared to the direct strategy which sounds compelling and commanding.

In the situations involving unfavored predicaments (scenarios 3–4), positive politeness was not preferred. Though speaker's empathy is appreciated in such situations, there is no actual need to word it out. What the hearer needs more is to be provided with a practical solution. Both female and male participants preferred negative-politeness strategies in these scenarios. In scenario-3, the yes/no interrogative form acknowledges the listener's autonomy and involves them in decision-making. In scenario-4, the declarative concisely explains the problem and offers an applicable solution. The direct strategy was also preferred in scenarios 3-4 because some participants value straightforwardness and clarity of communication in such situations.

Female participants preferred negative politeness when being instructed to schedule a future visit (scenario-5). The conventionally indirect form here '*Is it possible for you to do X?*' communicates more respect, considering that the doctors are often younger than the participants in our sample (as reported by 54% of participants). Some female participants also valued the direct strategy which reflects a sense of commitment by the doctor towards the patient. On the other hand, male participants preferred a direct strategy with female doctors and a negative-politeness strategy with male doctors. This shows that participants appreciate a balanced approach between clarity of instructions and consideration when communicating with their doctors. Positive politeness was not preferred in this scenario, suggesting that a more decisive rather than friendly communicative style is required in such situations.

Both female and male participants highly preferred positive politeness strategy in the situation where the doctor is supposed to support an apprehensive patient (scenario-6). As the doctor is expected to show maximum empathy, understanding and possibly guidance, a positive-politeness strategy was more fitting. Participants' preference for positive politeness in this situation aligns with the mainstream cultural conception that speakers of the Arab society are oriented towards positive politeness more than their counterparts in other western societies [27]. Speakers within a collectivist society like Arabs prioritize group harmony and interpersonal relations over individuality and privacy [30].

In summary, the preferences highlighted in this analysis reflect the complex interpersonal dynamics involved in D–P communication and the effect of the target communicative function. The politeness patterns recognized here emphasize the necessity for healthcare providers to tailor their communication approaches to accommodate the distinctive emotional and practical demands of male vs. female patients, and of younger vs. older patients. Such customization of communication strategies is essential to enhance the quality of healthcare delivery.

5. Conclusions

The argument that Arab speakers tend to avoid direct forms in favor of indirect forms that rely on group connectivity and mutual understanding between interlocutors is rather supported by the findings of the current study. In four out of six situations, participants showed greater preference for negative politeness, which marks respect between interlocutors in a formal and institutionalized setting. In contexts requiring extra psychological support or medical guidance, positive politeness was preferable. Apparently, participants preferred medical advice via positive-politeness strategy as it presents the target action as a joint task between doctor and patient, which encourages patient's compliance. Direct strategies were least favorable overall, though some participants preferred this approach in situations requiring straightforward explanation of the ongoing arrangements.

Female participants did not significantly vary their choices based on the gender or age of the doctor. The difference in descriptive statistics between strategy choice when the doctor is male or younger than the female participants was marginal. On the other hand, male participants were

more sensitive, particularly to doctor's gender factor. In four out of six situations, male participants either selected a different politeness strategy with a female doctor or used the same strategy with a different rate (higher or lower) when the doctor is female or younger. While modern media has westernized the Kuwaiti society and induced the development of non-traditional practices in male-female interaction, the community at large remains mostly gender-segregated in government and many private educational institutions, most public spaces such as mosques, health clubs, and beauty salons, and some workplace departments [32]. In such a traditionally gender-segregated community, males might have felt greater need for expressing deference in communication with members of the opposite gender.

The current study was challenged by some limitations. First, the ratio of male–female in the sample was not evenly distributed despite the authors' efforts to balance it during the data collection phase. Such imbalance reflects the overall society where females significantly outnumber males. The authors will strive to achieve a more gender-balanced sample in future research.

Second, the distinction between the three politeness-strategy types is not always clear cut, which might have affected the selection of participants. Indeed, certain situations, just as in many real-life situations, require the use of more than one communicative approach to deliver the speaker's intended message. Furthermore, patients' preference of a certain linguistic form could be influenced by factors beyond their politeness-orientation such as religious believes, sociocultural values, and their temperament when completing the MC questionnaire. A more detailed inquisition of participants' background is required in future research to detect the influence of such factors.

The third limitation concerns the scenarios in the MC questionnaire. While they assess a range of communicative functions common in D–P interaction, the inclusion of more scenarios could yield more comprehensive results. The authors here abided by the situational prompts eliciting doctors' responses from the original study [10]. In future research, the range and nature of situational prompts could be expanded.

Still, the current data represents a reliable source for understanding the general politeness orientations of Arab patients in the context of clinical visits. The findings presented here should be considered by healthcare providers and linguists when dealing with this sample of interlocutors. In their communicative skills training programs, medical students and doctors should be educated to understand the dominant politeness preference of each patient group (male vs. female, younger vs. older) and use the corresponding strategy in patient-directed speech to improve healthcare communication and outcomes. Our findings further provide an opportunity for cross-cultural comparison with non-Arab patients' group to test the universality degree of a certain linguistic politeness pattern.

Author Contributions

Conceptualization, N.A., and A.A.; methodology, A.A.; software, E.A.; validation, N.A., A.A., and E.A.; formal analysis, N.A., and E.A.; investigation, N.A., and A.A.; resources, N.A.; data curation, E.A.; writing—original draft preparation, N.A.; writing—review and editing, N.A.; visualization, N.A., and E.A.; supervision, E.A.; project administration, A.A.; funding acquisition, None applicable. All authors have read and agreed to the published version of the manuscript.

Funding

This work received no external funding.

Institutional Review Board Statement

Not applicable.

Informed Consent Statement

Participants consent was granted by agreeing to complete the MS forms in the first place, after reading the project's statement with the names of the conducting authors. Any participant who did not consent has never responded to the MC questionnaire items.

Data Availability Statement

Data supporting reported results is available upon request as excel sheet review. Interested readers and scholars may contact any of the authors in this regard.

Conflicts of Interest

The authors declare that there are no conflicts of interest regarding the publication of this paper. The research was conducted independently, and no financial or personal relationships could have inappropriately influenced the work reported in this paper. All data and materials used in the study have been disclosed and remain available for review by the relevant bodies upon request.

Abbreviations

Doctor–Patient (D–P); General Practitioner (GP); Face-Threatening Act (FTA); Kuwaiti Arabic (KA).

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