NEGOtiATION STRATEGIES AND PATIENT EMPOWERMENT IN SPANISH AND BRITISH MEDICAL CONSULTATIONS

ABSTRACT

Making a decision is not only one of the physician's most important responsibilities and one of patients’ most sensitive moments in medical events, but also a potential difficulty in effective health communication, which becomes compounded when cross-cultural variation comes to play. Taking this into consideration, this paper examines and interprets the decision-making strategies that General Practitioners (GPs) and patients employ in 80 follow-up encounters in England and Spain. The results show that such strategies are subject to role specifications: while patients may make use of (dis)agreement strategies and initiate decisions and/or self-diagnosis, doctors give options, show empathy, expand explanations or show explicit or implicit (dis)agreement. In relation to this, notable findings were revealed: first, these communicative strategies and the perception of power asymmetries considerably vary across cultures, not only in terms of quantity, but also quality and distribution; second, Spanish interlocutors tend to negotiate through the explicit expression of opinions, while British interlocutors prefer the discussion of different alternatives and value the other's freedom to act. Third, there is a higher tolerance of disagreement in the Spanish data, which may indicate that disagreement and conflict need not be related. Fourth, negotiation may be undertaken on the basis of either self-affirmation or consensus-seeking beliefs. Finally, patient empowerment is displayed in divergent ways in both sets of data.

Keywords: negotiation, decision-making, cross-cultural communication, power, self-affirmation, consensus
1. INTRODUCTION

Research on doctor-patient communication and decision-making processes has generated well-grounded evidence that effective interpersonal skills in healthcare contexts can not only improve patient satisfaction and adherence to treatment, but also the doctor’s adequate provision of information, adequacy of diagnosis and success in treatment related decisions (cf. Hall et al. 1994; Iedema 2007; Kalbfleisch 2009; Rivadeneyra et al. 2000; Street et al. 1993; Street 1991, among many others). In fact, given that cultural assumptions, institutional values, professional experiences and communicative styles are all in full display in doctor-patient events (Candlin and Candlin 2003; Cordella and Musgrave 2009; Roberts and Sarangi 2002), the mismanagement of decision-making episodes may constitute a serious threat to the quality of patient care (Hewett et al. 2009). What is not so clear is what we mean by ‘adequate’ or how to aim at patient satisfaction. Moreover, the impact of culture-specific communicative styles in negotiation on effective doctor-patient communication still needs further investigation (Long Feather 2007; Pesquera Yoder and Lynk 2008). Together with potentially varying power asymmetries across cultures (Locher 2004), this may lead to variation in terms of effective communication.

On the other hand, since medical events are very sensitive for patients, and considering that both parties in interaction have a common goal (health problem-solving), it is expected that negotiation and interpersonal work will be developed (Campbell 2005; Mullany 2009). In this sense, and also considering that negotiation skills considerably vary from culture to culture (Fant 1989, 1995, 2007; Kalbfleisch 2009; Valbuena de la Fuente 2003; Van Wieringen, Harmsen and Bruiijinzeels 2002), how both doctor and patient negotiate decisions and deal with treatment-related issues is expected to vary as well.

With the exception of a few studies (cf. Hewett et al. 2009; Street 1991), decision making research has largely been limited to clinical decisions made by physicians, who usually assume responsibility for health care decisions. However, as indicated by Broadstock and Michie (2000), patient participation in the decision making process should be addressed in current research, as “physicians who have not established a relationship with the patient or with someone the patient knows may not be able to fruitfully ask questions and gain useful answers” (Kalbfleisch, 2009). This study will examine both doctors’ and patients’ decision making strategies as a cooperative process in which both interlocutors influence each other in interaction (Cordella, 2007; Young and Flower, 2002). The initial assumption will be that negotiation encompasses a wide range of strategies and styles that are intrinsic to each situation. In other words, what is considered to be appropriate negotiation in one context, is not necessarily considered so in another. Therefore, appropriateness will be constrained by situational, individual, cultural and social aspects intertwined in interaction. It is a move from doctor or patient examination of communication towards interpersonal communication as a dynamically shaped activity.

Some of the current literature found suggests that participants in medical consultations are equal in the negotiation process. Bissell, May and Noyce (2004) label this as ‘concordance’ or, in other words, the fact that doctor and patient work together to achieve the goal of managing health-related issues. Nonetheless, I believe that this statement may be too categorical when applied to a cross-cultural context, as power asymmetry is a culture dependent variable that needs to be tackled accordingly. Power
asymmetries are in fact expected. However, it will obviously depend on the type of power that is at stake. In medical encounters, institutional power and expert power lie on the doctor’s role (Erzinger 1991; Harrison and Barlow 2009) in general terms. However, cultural differences in the ways these variables constrain interaction are expected. On the other hand, interactional power, that is, power that is negotiated in the ongoing process of communication (Locher 2004; Mills 2003), needs to be considered in a context in which decisions are to be made by both doctor and patient, or situations in which the interlocutors negotiate power in interaction. Thus, power becomes an ongoing process that is strategically developed (Guilfoyle 2005; Sarangi and Slembrouk 1997; Wang 2006). In other words, power may be pre-established by the institution, given by the knowledge doctors have, achieved interactionally (i.e., usually patients may want to have power to make their own decisions) and even granted by the other interlocutor; in this last case, doctors may, for instance, empower patients to temporarily be able to make decisions, negotiate and give opinions on health-related topics as a strategic empathic use of language (Cordella and Musgrave 2009). Studies like Brown et al.’s (2006) support the idea that patients who can express their opinions, and get involved in treatment-related decisions achieve more satisfactory communication with their doctors.

A different issue would be how these pre-established power asymmetries, granted empowerment or interactionally self-acquired power rights are implied in communication. Cordella (2007) argues that health professionals tend to use reprimands when patients fail to adhere to a particular treatment, as a sign of power asymmetries. In this sense, being assertive and direct in communication seems to be related to exerting power. Nonetheless, my study is undertaken under the assumption that power asymmetries may be linguistically expressed in a wide range of strategies that may not be necessarily based on directness and assertiveness. Additionally, it is worth noting that cultures hold varying beliefs in terms of tolerance to disagreement and conflict (Locher, 2004). One of the multiple devices used to express this communicatively is through the expression of either consensus (i.e., search of agreement) or self-affirmation as the expression of assertiveness (Cohen et al. 2009; Fant 1989; 2007; Heine and Lehman 1997; Sherman 2006; Steele 1988). Claude Steele (1988) first proposed the theory of self-affirmation, which explains that human beings are naturally predisposed to protect or enhance self-integrity and self-worth in various ways. In terms of communication, how this disposition is reflected varies from culture to culture, depending on conventional communicative styles. Steele claims that one of the clearest manifestations of self-affirmation is assertiveness and the expression of one’s thoughts, i.e., a speaker centered attitude in interaction.

For these reasons, my aim is to provide a rich set of analytical tools that may help understand contemporary health care practices across cultures and, in particular, in British and Spanish medical consultations, with special attention to those negotiation strategies and communicative styles revealed when making decisions, which may ultimately affect health outcomes. Thus, the goal of this study will be to answer the following questions: What decision-making dynamics and strategies are displayed between doctor and patient? Does variation exist between Spanish and British decision-making processes? What does this say about the cultural perception of doctors and patients in Britain and Spain? What sociocultural beliefs underlie varying communicative styles in doctor-patient communication? What is the relationship between decision-making styles and power expectations? In what ways do interlocutors seek agreement or self-affirmation attitudes when negotiating decisions? By answering...
these questions, consequences for improvement in intercultural communication and interpersonal communication management may be unravelled.

2. DATA AND APPROACH

The data analysed consist of 80 interactions between General Practitioners (GPs) and patients, recorded in different geographical areas in England and Spain and transcribed accordingly. The interactions were randomly chosen out of a set of 120 English interactions and 60 Spanish interactions.

The 40 Spanish interactions were recorded after obtaining permission in four different healthcare centres in Huelva, Seville, Badajoz and Madrid. Thus, the data collected cover the centre and south of Spain. The transcript notation of the Spanish interactions was adapted from Atkinson and Heritage (1984).

Patients were previously informed about the research and its goals, and only those who agreed to be recorded in successive consultations were included in this study. This means that the interactions utilized for this study are based on follow-up sessions in which doctor and patient were not meeting for the first time. Therefore, the type of rapport between interlocutors is relationship-renewing instead of relationship-shaping (Heritage, 1984). Since all those involved had been told about the recording in advance, by the time the consultation took place the naturalness of the interactions did not appear to be distorted.

The English data belong to the British National Corpus, characterised by being monolingual (it covers modern British English) and synchronic. As expressed in the corpus’ website (www.natcorp.ox.ac.uk), the data collected are demographically and geographically representative, with equal number of interactions taken from every region in England.

In both corpora interactions with the elderly (85 years old and older), teenagers and children, as well as first time encounters were not included, as these factors may influence the way interaction evolves. All the interactions included in this study deal with physical illnesses, since psychological problems reflect a different type of negotiation and decision making between doctors and patients (cf. Bartesaghi 2009).

A basic quantitative, inductive study will determine the relevance or salience of negotiation strategies in the decision-making process, identified in doctors as option giving, empathy, expanding explanations and (dis)agreement; and in patients as (dis)agreement strategies, decision-making and/ or self-diagnosis. These strategies are not directly based on a specific theoretical framework but unravelled after the examination of data and the reactions interlocutors display in interaction. The focus of the analysis is the dynamics involved in decision making, i.e., who makes decisions, who takes initiative, how frequently such situations occur and at which stage in the interaction. Besides whether there is explicit disagreement and, if so, how this is solved is also taken into consideration. This leads to the creation of a taxonomy of strategies. The patients’ and doctors’ strategies will be first analysed separately in the British and Spanish corpora. Cross-cultural similarities and differences will be addressed subsequently. Variation in terms of quantity may reveal variation in terms of
communicative styles in negotiation, and eventually, qualitative variation in terms of value preferences.

A qualitative study will reveal the overall negotiation dynamics undertaken between doctor and patient in the two sociocultural contexts analysed. In this second stage of analysis I will discuss the impact of negotiation styles and interactional dynamics on power asymmetry and cultural beliefs.

3. Negotiation strategies in the decision-making process

Taking into account that doctors assume the role of helpers in contrast to the helped (patients), they may have different rights and obligations in the negotiation of power relationships (Bartesaghi 2009: 16). The data examined also revealed that this negotiation varies cross-culturally and is reflected in communication in various ways. In particular, differences were found in the dynamics involved in the decision-making process, i.e., who leads the interaction and how decisions are made. Methods for decision-making in the medical interview may range from the delegation of decisions to the doctor to patients taking initiative and deciding themselves; this will ultimately depend (among other factors) on the interlocutor’s values, preferences and communicative expectations (Broadstock and Michie, 2000; Pierce, 1996).

3.1. Patients’ initiative and negotiation

The analysis of the data led to the taxonomy of a series of strategies in the decision-making process—which could occur simultaneously or not—in patients:

a) Full agreement: the patient is happy with the recommendations made by the doctor.
b) Decision-making: the initiative is taken by the patient in order to make health-related decisions, such as the suggestion of a particular treatment.
c) Self-diagnosis: the patient suggests a potential diagnosis and/or treatment-related preferences.
d) Implicit disagreement: there is an attempt to change the course of decisions in an implicit way. For example, providing options.
e) Explicit disagreement: the patient shows verbal disagreement.

Both explicit and implicit disagreement are different ways of expressing potential non-compliance (Cordella, 2007), which is determinant for the success (or lack thereof) of the treatment and eventually a particular ailment’s cure.

When comparing the negotiation strategies previously mentioned in patients in terms of quantities, the results were:
Figure 1: Percentages of patients’ strategies in negotiation.

Extract 1, taken from the British National Corpus, and extract 2, taken from the Spanish corpus, illustrate this variation. First, extract 1 shows not only the search of agreement but also how the doctor is not explicit in the decision-making process:

Extract 1

D  [88] it may well be allergy mediated to h pollen or dust or something like that.
   [89] So it may just be a seasonal thing.
   [90] But I I think the diagnosis is asthma or whatever t whatever's triggered it off.
   [91] And we need to treat you along those lines.
P  [...] 
D  [92] Now.
   [93] The drugs of choice for asthma are inhaled drugs.
P  [94] Yeah.
D  [95] Then you can either use very small doses, they go straight to the lungs, or
P  [96] Mm.
D  [97] they work without any particular side effects.
   [98] And you can use inhalers like this, or you can use inhalers like this.
P  [99] Mm.
D  [100] You can use inhalers like th this puffer type.
P  [101] Yeah.
D  [102] Okay.
   [103] And what I suggest we do is seeing Georgina's here we send you through to see Georgina and she can, if she's got time, we can briefly run through one or two types.
   [104] See which
P  [105] Mm.
D  [106] suits you best.
P  [107] Yeah.

As reflected in turns [93], [95] [98] and [100], the doctor gives options to the patient. Turn [103] shows that, instead of telling the patient what to do exactly, he provides options or suggests indirectly; in this sense, the possibilities for disagreement are taken out of the picture.
In contrast, extract 2 is an example of a temporary lack of consensus:

**Extract 2**

P [12] además de la receta /que a mí me están dando unos mareos todo el tiempo
   besides the prescription /which are making me feel dizzy all the time

D [13] Sí
   Yeah

P [14] que esto mejor me parece que tengo una migaja de colesterol /¿por qué no me mira usted los oídos o?
   *I think I probably have a bit of cholesterol / why don’t you have a look at my ears?*

D [15] no, hombre
   *No*

P [16] ¿Por qué no me hace usted una analítica?
   *Why don’t you give me a blood test?*

D [17] no, hombre
   *No, come on now*

P [18] una vez me subió a 20 la tensión, eh
   *Once my blood pressure went up to 20*

D [19] a ver la receta
   *let’s see the prescription*

P [20] era- /dígame usted todo lo que usted sepa de mi enfermedad
   *tell me everything you know about my illness*

D [21] [...] *(printing prescription)*

D [22] Ya hace tiempo que no te haces analítica, ¿verdad?
   *It’s been a long time since you last had a blood test, hasn’t it?*

P [23] sí, por eso le digo, la última fue a ver si tenía colesterol, ¿sabe usted? Ponga usted lo que crea, pero sobre todo colesterol, Don José, el colesterol
   *Yes, this is what I was saying, last time I went to see if I had cholesterol, you know? Write down whatever you think, but most importantly cholesterol*

D [24] pues ya está, ya está
   *That’s it*

**Turn [14]** shows the patient’s self-diagnosis (a non-existent strategy in the British data) and initiative in making decisions, which appears together with turn [16], in which the patient requests a blood test and later on, in turn [23], he suggests some solutions, even before the doctor establishes any diagnosis and/or treatment. Despite the immediate refusal to accept the patient’s decisions (doctor’s explicit disagreement), the doctor retakes the issue some turns later and finds a middle position to please the patient and to enable his cooperation. In this way, the doctor attempts to successfully administer what he considers to be appropriate action to remedy the health problem. In other words, there is an attitude of closeness and empathy with the patient in this sense, who in turn changes to a more cooperative attitude when the doctor tells the patient that he will have to take some additional action to remedy the health problem.
3.2. Doctors’ initiative and negotiation

The strategies described occur in combination with a series of negotiation strategies identified in doctors:

a) Giving options: instead of imposing a specific treatment or action to be taken, the doctor suggests different possibilities and explains the advantages and disadvantages of each of them.

b) Empathy: the doctor attempts to show solidarity with the patient’s opinions and feelings (Cordella and Musgrave 2009). This could refer to expressions such as “I understand how you feel” or “we’ll try to make you feel better”, used to eventually gain patient’s cooperation in the decision-making process.

c) Expanded explanations: the doctor gives further arguments to support recommendations or instructions.

d) Implicit disagreement: sometimes what the doctor thinks is the best solution does not match the patient’s wants or needs, so the doctor tries to show how these are not suitable without explicitly contradicting the patient.

e) Explicit disagreement: the doctor’s open expression of disagreement.

f) Decision-making: the doctor decides without the patient’s involvement.

The quantities and distribution of decision-making strategies identified in doctors are summarized in figure 2 below:

![Figure 2: Spanish and British negotiation strategies led by doctors.](image)

The most significant aspects in figure 2 are that: 1) while 87.5% of the interactions contain agreement in British doctors’ turns, it only occurred in 15% of the Spanish interactions; 2) while Spanish doctors use a range of disagreement strategies (35%) that can be either explicit (17.5%) or implicit (17.5%), British doctors disagree more frequently in the data, but only implicitly (55%). Explicit disagreement was nonexistent in the British data; and 3) British doctors prefer giving options to the patient in many of the situations (35%) while this only occurred in one Spanish interaction in the data, or, in other words, Spanish doctors tend to make
decisions without empowering patients to do so (70%) when compared to British doctors, who only make explicit, autonomous decisions in 27.5% of the interactions.

These strategies do not appear isolated but rather combined in a way that the dynamics between doctor and patient integrates a variety of strategies that involve different orientations in communication across cultures. What was clear with the identification of these strategies is that they are role-related ways of addressing the interlocutor, either by seeking consensus (full agreement, doctor-led decisions) or being assertive (i.e., showing disagreement, taking initiative).

Extract 3 shows some of patients’ and doctors’ strategies combined:

Extract 3

D [65] ¿Le duele por aquí?
Does it hurt here?
[...]

P [76] ahí justamente en ese hueso de la cadera
Right there, in the hip bone
[77] [...]  

D [78] esto ya es el sacro, ¿eh?
This is the sacrum, ok?

P [79] la verdad es que tengo un poco de osteoporosis
To tell you the truth, I think I have a bit of osteoporosis

D [80] no, pero esto no es eso. Aquí en las mujeres es muy frecuente una obusitis que se forma aquí
No, this is not the problem. It’s very frequent to find obusitis in women
[...]

D [84] [...]  

P [85] y yo diciendo la hernia Esto es que me irradiía el problema lumbar que tengo hacia abajo
and the whole time I was thinking it was a hernia. It may be that my lumbar problem irradiates downwards.

D [86] en la mujer, con la estructura que tiene el sacro es muy típico la (...) a nivel sacro (...) sea una obusitis o sea a nivel artrosis negativa a nivel sacro, lo cierto es que hay un nervio y por eso duele tanto
Due to female sacrum structure this is very frequent, either related to obusitis or to negative artrosis. What is true is that there’s a nerve affected and that’s why it’s painful.

P [87] Claro yo tengo artrosis realmente en las manos y =
Yeah, I actually have artrosis in my hands.
[...]

D [94] Aquí viene muy bien la rehabilitación / es decir / yo lo que diría es que se pusiera calor local, eh / diez minutos nada más al día
Rehabilitation is very good for this. That is, my advice for you would be you to apply heat to the affected area ten minutes each day.

P [95] sí
[...]
Yeah
¿Y protector me tomo? Porque yo me estaba tomando Omeoprazol porque tengo problemas de estómago y tenía dolores sobre todo cuando tomo Etamil.

Should I take some sort of stomach medicine?? I was taking Omeoprazol because I have problems with my stomach and I had aches, mainly when taking Etamil.

Yo el Etamil no es santo de mi devoción por qué no decírselo

I’m not very fond of Etamil, I’m telling you.

vamos que no me lo estoy tomando porque cuando tomo ibuprofeno

well, I’m not taking it now because I’m taking Ibuprofen.

This is a clear example of how patient’ self-diagnosis (turns [79] and [87]) and initiative to make decisions (turn [97]) is combined with the doctor’s disagreement (turn [80] and [98]) and the expansion of explanations (turn [86]) in order to not only negotiate a treatment-related decision, but also to define the problem. This shows how these strategies do not operate in isolated ways but make sense in interaction.

These results have different implications: first, that British doctors not only interact much more than Spanish doctors, but they also lead the interaction and use a wider range of negotiation strategies, such as the provision of options grounded on medical explanations; in contrast, Spanish doctors usually orient themselves towards responding to their patients’ assertiveness and demands during the interview. This can be translated as different profiles in the professional sphere, in which British doctors tend to be more active in communicative terms, leading the interaction in terms of structure and content (by showing empathy, asking questions, giving options, expanding information, showing implicit disagreement, etc). Spanish doctors seem to be rather focused on the transaction itself, and go into the negotiation process once patients show their willingness to do so. Second, these results show how explicit disagreement is nonexistent in British interactions. Implicit disagreement, in contrast, is undertaken in the form of the doctor guiding patients towards a particular decision, without incurring in the conflict implied from explicit, clear disagreement. And finally, negotiation exists in both contexts, but whilst the British corpus shows a preference for negotiating in more subtle ways (doctors seem to prefer giving options and showing agreement or implicit disagreement as main strategies), Spanish interlocutors prefer more explicit negotiation (with a tendency towards taking initiative or showing clear disagreement when necessary).

3. 3. Interactional dynamics of negotiation

In terms of communicative beliefs, data revealed a varying preference towards consensus (exemplified in episodes of full agreement, the display of empathic attitudes or the provision of options) and self-affirmation or assertiveness (as revealed in disagreement, self-diagnosis, the initiative taken by the interlocutor or the expansion of explanations). For instance, figure 1 reflects a much higher percentage of interactions containing full agreement in British patients (90%) than in Spanish patients (65.5%), the latter showing assertiveness or self-affirmation in 35.5% and the former, only in 10% of the interactions. Figure 3 shows variation in terms of the amount of interactions with
negotiation of decisions in contrast to those in which the decision made by the doctor is simply accepted:

![Figure 3: distribution of episodes showing either consensus or self-affirmation in patients.](image)

This can be translated as a need to seek consensus and/or stick to institutional roles in the case of British patients, as compared to the Spanish patients, whose interactional features show that disagreement, decision-making and self-diagnosis are part of the dialectical speech between doctor and patient, as examples of an assertive attitude. In this sense, explicit negotiation is rather more common in Spanish than in British contexts.

In the case of doctors, we may consider disagreement, decision-making and the expansion of explanations as different forms of self-affirmation, whilst full agreement, empathy and the provision of options to the patient may show a communicative desire to reach consensus. Taking this division into account, the levels of consensus and self-affirmation in doctors may be represented as shown in figure 4 below:

![Figure 4: distribution of episodes showing consensus-seeking and self-affirmation strategies in doctors.](image)

Figure 3 still shows a prominence of self-affirmation in Spanish doctors, with less frequency of full agreement. Even though British doctors also show high frequency of self-affirmation in medical consultations (which is expected, given the assumed institutional power of physicians), they also display a full range of strategies (empathy, providing options, agreement) to display consensus with the patient.
These aspects reflect culturally-biased ways of approaching the same reality, which can be seen as consensus-seeking or assertiveness/ self-affirmation oriented (Steele 1988; Thurén 1988; Fant 1989, 2007; Hernández López and Placencia 2004). Considering that the strategies detailed above imply a varying desire to say what one thinks, we may say that the Spanish interlocutors in the corpus analysed orient themselves towards self-affirmation. This means that saying what one thinks is positively valued in society even when there is a difference in terms of status. The way interactants maintain or enhance rapport may be then based on the explicit statement of thoughts. In this sense, we are pointing at a reformulation of what disagreement implies in interaction, in a way that it is not necessarily seen as a negative aspect in institutional communication, but as a way to communicate effectively, sharing one’s thoughts and leading to efficient decisions. As Fant argues, “Hispanic speakers will simply tolerate a much higher degree of disagreement [than Scandinavian speakers] without incurring the risk of conversational breakdown” (1989: 251). In contrast, the vast majority of British interactions show a desire to maintain consensus and agreement with the doctor, which is translated into a desire to avoid conflict situations. In other words, one same aspect in communication –agreement/disagreement and the expression of one’s thoughts- may be culturally codified as either self-affirmation (or the desire to show one’s assertiveness) or consensus-seeking (or the willingness to show agreement and conflict avoidance with the interlocutor).

These divergent ways of interacting will clearly affect the dynamics developed in interaction. Thus, providing options instead of imposing, for instance, must bring consequences for the listener, whose response is in a way constrained by the interlocutor’s previous turn (Street, 1991). Taking into account that it is in both doctors’ and patients’ interest to reach agreements, we may say that varying ways of making the pieces fit may lead to different perceptions of how to maintain or enhance rapport (Spencer Oatey 2000, 2008).

Observation of the previous strategies as a whole may help understand that negotiation in Spanish interactions is characterised by being explicit and assertive, based on the categorical exposure of each one’s way of thinking, whereas British interactions are rather characterized by the implicit exposure of thoughts and ideas, mainly seen in the patient’s lack of disagreement and the doctor’s provision of options, implicit disagreement and the provision of further explanations when necessary. All this boils down to two different main dynamics in interaction, as summarized in figures 5 and 6:
Figures 4 and 5 correspond to the dynamics developed in the interactions previously detailed, based on assertive negotiation. When B (usually the patient) agrees, negotiation ends and agreements are reached (65.5% of the interactions which resulted in negotiation). When there is some kind of disagreement or initiative from the patient (35.5% of the interactions), the dynamics in 2) in the figure above is developed: either the doctor tries to use different strategies (being empathic, expanding information, etc) to persuade the patient, or the doctor chooses a middle position in order not to contradict the patient but gain the patient’s cooperation. This was illustrated in extracts 2 and 3. In contrast, the British dynamics encompass a certain subtleness on the basis of consensus seeking as main concern for the interactants, as detailed in figure 6 below:

Figure 6: dynamics of negotiation in the decision-making process in the British medical consultations analysed.

The pattern of implicit negotiation shown in figure 6 appeared in 35% of the British interactions (it is to say, all the interactions in which decisions are shared) As can be seen, there is seldom room for disagreement from the very beginning, due to the
doctor’s constant provision of options and guidance towards the most adequate choice. Needless to say, these are general patterns corresponding to the strategic use of negotiation in those patterns with higher frequency expressed in sections 3.1 and 3.2.

**DISCUSSION AND CONCLUDING REMARKS**

This study represented an attempt to account for systematic differences in physician’s and patient’s negotiation strategies as culturally-biased factors in communication. This study highlighted the importance in understanding how diverging decision-making processes are developed in British and Spanish medical events.

The results reveal that while the Spanish data show negotiation through the explicit expression of opinions, British interactions are much more subtle in this respect. Given that the doctor’s provision of options is frequent, negotiation is focused on giving options, rather than agreeing or disagreeing explicitly, whereas Spanish doctors and patients say what they think more straightforwardly. This may lead to situations of disagreement after the successive expression of assertive opinions. These findings are consistent with those in Street (1991), who affirms that American patients may assert their perspective “by offering opinions about diagnosis and treatment, disagreeing with the doctor, making recommendations, and so forth” in a way that “a patient’s expressiveness and assertiveness may influence the doctor’s informativeness” (542). Nonetheless, considering that GPs aim at finding appropriate action once patients seek help, disagreement can not always be related to conflict but to an attempt to jointly find the best solution.

In contrast, the results found in the British data are closer to those found by Lehtinen (2007: 423: 424) in Finnish medical consultations; the author explains that the way interactants manage disagreement is by showing that in fact there is not such disagreement. Instead, the doctor either expands information in order to show that both possible options are related (and not opposed), or gives the patient reasons to think that the doctor’s perspective has more advantages than disadvantages. In any case, the doctor gives different alternatives, avoiding open confrontation with the patient. Whatever the strategies developed, this is a dynamic process, indeed, in which high involvement and negotiation are present in order to fulfil both doctors’ and patients’ interests and expectations.

This leads to the fact that societies develop varying degrees of tolerance towards disagreement. In this sense, the Spanish data show that disagreement need not be related to conflict or rapport threat (Spencer-Oatey 2000, 2008), but to particular negotiation strategies that are typical in this sociocultural context. Therefore, and on the basis of previous literature (Fant, 1989, 1995, 2007) self-affirmation is part of the dialectical nature of Spanish interlocutors in negotiation episodes, where the expression of beliefs and opinions is accepted and expected. Once this occurs in patients, they empower themselves in interaction. In turn, consensus seeking is typical in British medical consultations, in a way that disagreement could be perceived as conflict or rapport-threatening. As a consequence, patients are very often interactionally empowered by doctors, who own institutional and expert power to do so. The dynamics explained is then dependent on the degree to which power relationships are perceived as fixed or flexible in communicative terms, how patient centeredness is perceived and in what ways they are empowered in negotiation.
It has been assumed that patient involvement may enable medical options to be chosen according to particular values and expectations (Broadstock and Michie, 2000; Pierce, 1996). This study, though, has problematized the fact that there are many ways of being involved, in the same way that the communicative realization of a specific situation as disagreeing may imply different sociocultural values. In this vein, we may affirm that the preferred options for Spanish and British interlocutors when making decisions vary considerably, the former being oriented towards patient self-empowered decision making and the latter towards the delegation of decisions to doctors, who at the same time empower patients to participate.

In other words, the data analysed reflect that the British interlocutors examined in the medical encounter prefer an informed decision (someone may make a reasoned decision based on their doctor’s suggestion), as there is a previous step in which doctors give options to the patient, or ask more questions in order the support the decision to be made. This contrasts with the autonomous decision (Broadstock and Michie 2000; Redelmeier, Rozin and Kahneman 1993) of the Spanish patients analysed, who spontaneously seek solutions and provide them to the doctors, without a previous stage of information gathering.

Up to this point, it seems as if British doctors were more aware of the benefits of participatory decision-making with patients whilst Spanish doctors and patients are more autonomous and assertive. What is true, though, is that they reflect competing values in communication which are very much rooted in varying conversational constraints of deference and distance, by which British interlocutors tend to avoid imposition (Brown and Levinson, 1978, 1987) and seek consensus in interaction. In contrast, Spanish interlocutors display a tendency towards assertiveness or self-affirmation (Cohen et al., 2009; Fant, 1989; 2007; Heine and Lehman, 1997; Sherman, 2006; Steele, 1988) in which Spanish interlocutors show more autonomous behaviour. Whatever the attitude taken in decision making, it is far from being normative but principle and culture bound, what marks that an understanding on how to develop effective communication without incurring in rapport threat is based mainly on the observation of cross-cultural aspects of communication, such as those analysed here.

Despite these differences, what these interactions have in common is that both corpora reflect a patient-centred attitude. In the case of British interactions doctors provide options, seek agreement, show empathy and expand explanations. This contrasts with the Spanish patients, who show explicit disagreement, take the initiative and even suggest a possible diagnosis in order to place themselves as the focus of the interaction. The difference, then, would be that British doctors empower patients, while Spanish patients empower themselves. These are not clear-cut categories but cultural and contextual orientations.

All in all, the results revealed the direct relationship between linguistic choices, tolerance for disagreement, consensus or self-affirmation beliefs and patient empowerment variation. These aspects may have an impact on the importance of understanding cultural variation in negotiation, patient satisfaction and cooperativeness, as well as adherence to treatment and rapport enhancement in medical consultations.
REFERENCES


