

Review Article

Face-Work and Rapport in Medical Consultations: A Scoping Review of Empirical Studies, 1987–2025

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Abstract

Background: The ways in which doctors and patients safeguard each other's face, foster rapport, and soften difficult messages influence trust, satisfaction, and adherence. Although research on politeness in medical encounters has expanded rapidly, it remains dispersed across linguistics, communication, and health journals and has not been comprehensively organized.

Objective: This scoping review charts empirical research on politeness, face, rapport, and impoliteness within doctor–patient communication, detailing their locations, methodologies, theoretical frameworks, and reported strategies.

Method: Using the Arksey and O'Malley framework alongside PRISMA-ScR guidelines, 21 structured searches and 16 related-record look-ups identified 298 records. After excluding 137 duplicates, 161 records underwent screening and 91 reports were evaluated. Only empirical studies of doctor–patient interactions published up to May 2024 with a registered DOI were included. Data were charted by year, country, setting, data type, framework, and main findings, then synthesized descriptively.

Results: A total of 34 studies were analyzed, with 26 (76%) published from 2020 onward. China (11 studies) and Nigeria (6 studies) made up half of the research, while only two studies originated from Pakistan. Most studies examined face-to-face consultations (18), whereas all eight studies on online consultations were published after 2019. Brown and Levinson's model was the most common framework (19 studies), but all eight studies employing rapport management or relational work were conducted in China. No single communication strategy was predominant: negative politeness and mitigation appeared in 7 studies, positive politeness or rapport-building in another 7, bald-on-record directness was noted in 4, and 11 studies did not specify any strategy. Only five studies focused on patients' own politeness, and just one tested a statistical link between strategies and patient satisfaction.

Conclusion: Politeness during medical interactions is heavily influenced by the environment, purpose, and cultural context rather than adhering to a universal standard. The field requires additional research from underrepresented areas, such as multilingual South Asian regions, with a focus on patients' politeness, clear data reporting, and studies that connect politeness tactics to patient results.

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Introduction

A medical consultation involves several actions that can threaten a person's face, such as asking about sensitive symptoms, giving instructions, disagreeing with a patient's opinion, refusing requests, or delivering bad news. In politeness theory, face refers to the public self-image individuals want others to respect, and politeness involves linguistic strategies to preserve it [1]. When doctors handle these moments effectively, they can reduce patient anxiety and foster trust. Conversely, blunt or careless language may cause patients to feel dismissed. Therefore, politeness extends beyond good manners; it is a crucial part of how medical interactions are conducted.

Research in this area started with studies utilizing Brown and Levinson's model in Western consultations during the 1980s [2,3] and has expanded to various languages and contexts, such as government hospitals in Pakistan and Nigeria [4–6], and text-based online consultations in China [7,8]. New frameworks like rapport management [9] and relational work [10] have been added to the traditional models, and impoliteness has emerged as a standalone topic [11,12]. Since this research is published across linguistics, communication, and health journals, it's challenging to determine the overall knowledge, the sources of evidence, and the current gaps.

Significance of the Study

A map of this literature benefits three groups. For researchers, it highlights studied settings, languages, and frameworks, as well as gaps. For medical educators, it summarizes observed strategies across various encounters, aiding communication training. For researchers in multilingual countries like Pakistan, where consultations frequently switch between regional languages, Urdu, and English, it reveals the limited evidence available from their own contexts.

Problem Statement

Individual studies on politeness in medical encounters show diverse results: some characterize doctors as mainly direct, while others highlight their rapport-building or mitigating approaches. Without a comprehensive review, it's unclear whether these variations are due to actual differences across settings and cultures or just methodological and data discrepancies. No scoping review has yet synthesized the empirical literature on politeness, face, rapport, and impoliteness within doctor–patient communication.

Research Questions

1. Where, when and in what kinds of medical encounters has politeness in doctor–patient communication been studied?
2. Which theoretical frameworks and data types have these studies used?
3. Which politeness strategies do they report, and what gaps remain?

Research Objectives

1. To map the empirical studies by year, country, setting and participants.
2. To describe the theoretical frameworks and data used.
3. To summarize the strategies reported and identify gaps for future research.

Literature Review

Theoretical Frameworks for Politeness

The most influential framework remains Brown and Levinson's face-saving model [1], which differentiates between positive face—the desire to be liked and approved—and negative face—the desire to be free from imposition. It outlines four main methods of performing a face-threatening act: bald on record, positive politeness, negative politeness, and off record. Leech's politeness principle supplements this with maxims such as tact, generosity, approbation, modesty, agreement, and sympathy, all of which help speakers preserve good relations [13].

Later approaches shifted the focus from individual speakers to their relationships. Spencer-Oatey's rapport management framework incorporates sociality rights and interactional goals into face, analyzing how speakers build, sustain, or neglect rapport [9]. The relational work perspective considers politeness as just

one element of the broader effort to negotiate relationships, assessing behavior against the norms of a specific community of practice [10]. Conversely, impoliteness research explores behaviors that intentionally undermine face [11].

Politeness in Medical Encounters

Medical consultations are formal interactions characterized by clear knowledge and power asymmetries. Early research indicated that doctors' indirect, negative-politeness strategies could soften requests but sometimes rendered medical decisions ambiguous [2]. It also showed that medical students, when addressing patient refusals, often used everyday politeness habits that were not always therapeutic [3]. Since then, research has explored politeness in various contexts, including diagnosis and delivering news [6,14], negotiating hierarchy [15,16], addressing forms [17,18], and online consultations where text replaces face-to-face cues [7,19]. However, these studies have not yet been synthesized into a comprehensive map, which is the purpose of this review.

Materials and Methods

Study Design

A scoping review was performed following Arksey and O'Malley's five stages [20], incorporating Levac and colleagues' refinements [21], and documented in line with the PRISMA extension for scoping reviews (PRISMA-ScR) [22]. The record flow is shown according to the PRISMA 2020 format [23]. No protocol was registered.

Eligibility Criteria

Studies were included if they (a) analyzed interactions between doctors and patients, such as online consultations, recorded or broadcast sessions, role-played or elicited doctor-patient communication, and studies involving health workers where doctors participated; (b) explicitly examined politeness, impoliteness, face, face-work, rapport management, or relational work; (c) reported empirical data; (d) were published as peer-reviewed journal articles, book chapters, or conference papers by 31 December 2025; and (e) had a registered digital object identifier (DOI) to ensure source traceability. Studies focusing on nurse-patient, peer-support, or non-medical interactions, as well as theoretical papers, reviews, and theses, were excluded.

Information Sources and Search

Records were identified between 12 and 13 October 2026 through 21 structured web searches of scholarly sources and publisher platforms, combining terms for politeness (politeness, impoliteness, face, face-work, rapport, mitigation, terms of address, Leech, Brown and Levinson) with terms for medical interaction (doctor-patient, physician-patient, medical consultation, online medical consultation, telemedicine), with some searches targeted at regions (for example Pakistan, Nigeria, Indonesia, China and the Arab world). The full list of search strings is given in the Appendix. Look-ups carried out to retrieve the publication details of candidate records also surfaced related records; the records returned by 16 of these look-ups were screened in the same way. Every search and look-up, with all records returned and the decision on each, is listed in **Supplementary Materials (Table 2)**.

Selection of Sources

Records were de-duplicated and screened based on their titles and abstracts. Reports that met the criteria were retrieved from the publisher's site, the journal's website, or the OpenAlex database and evaluated for eligibility. The reasons for exclusion were documented for each report.

Data Charting and Synthesis

For each included study, the following information was recorded: authors, year, country of data collection, setting (such as face-to-face consultations, online consultations, broadcast media, questionnaires, or elicited and experimental data), data source and sample, theoretical framework, participants whose politeness was analyzed, and main findings. Data were extracted from the published abstract, the article page, or, when

available, the full text. If a detail was not reported, it was marked as “not stated” instead of being inferred. The most frequent or salient type of strategy reported by each study was also coded. Results are presented as counts and in a narrative synthesis structured around the research questions. Consistent with scoping review methodology, the quality of individual studies was not formally assessed.

Results

Selection of Studies

The search yielded 298 records, with 137 duplicates. After removing duplicates, 161 unique records remained, of which 56 were excluded based on title and abstract, mainly web pages, theses, theoretical papers, and studies on non-medical interactions. Out of 105 reports attempted, 14 were inaccessible. Among the 91 reports evaluated, 57 were excluded, primarily because they did not analyze politeness, face, or rapport (n=27), were unrelated to doctor–patient interaction (n=11), lacked a DOI (n=8), or were published in 2026 (n=6). Ultimately, 34 studies were included (see Figure 1). Their details are summarized in Table 1.

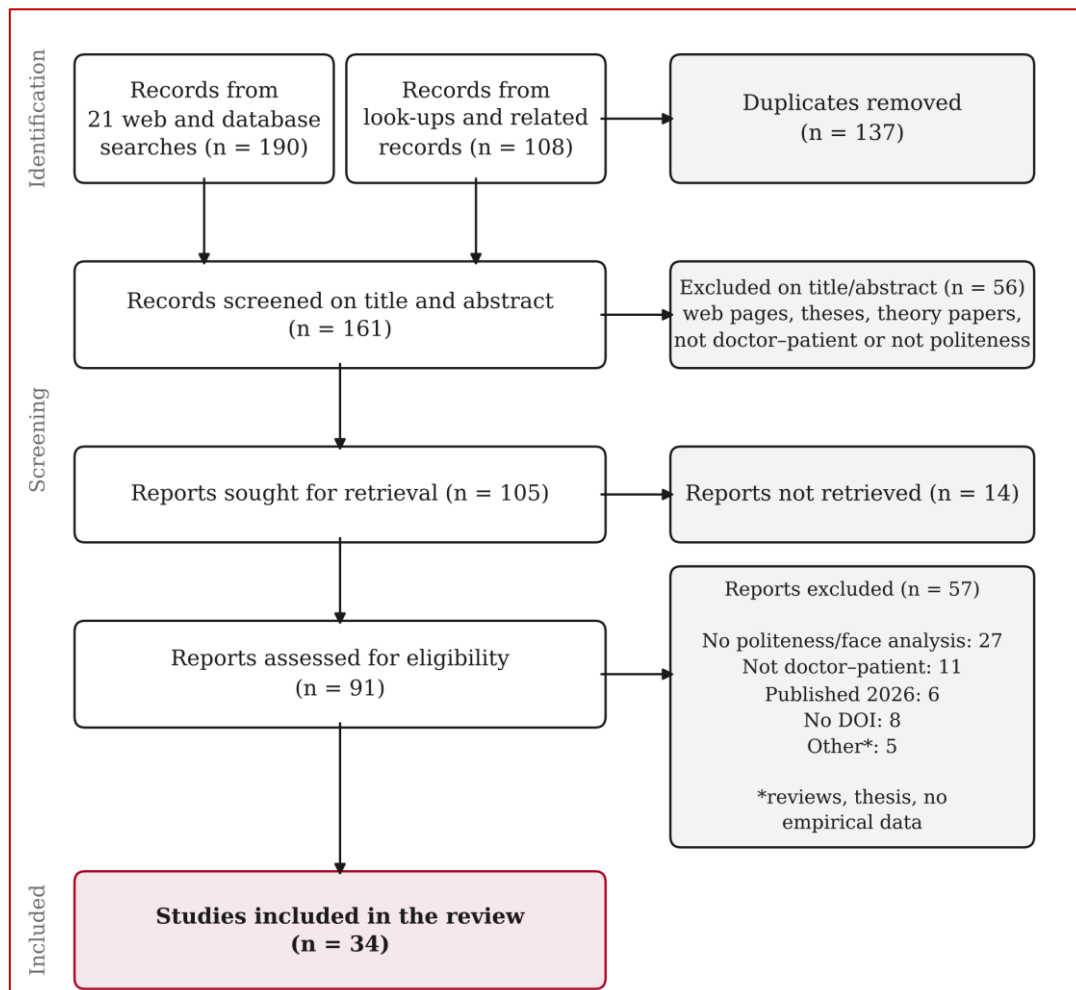


Figure 1: PRISMA 2020 flow diagram of the selection of studies

Table 1: Characteristics of the 34 included studies (in order of publication)

Study	Country	Data	Framework	Main finding
Aronsson and Sätterlund-Larsson (1987) [2]	Sweden	Consultation talk (details not given in abstract)	Brown & Levinson	Doctors relied on indirect, negative-politeness forms that softened requests but made communication vague; patients' minimal feedback left decisions unclear.
Robins and Wolf (1988) [3]	Not stated	Medical students' written responses to a treatment-refusal vignette	Brown & Levinson	About 90% of first-year students repaired the breakdown with everyday politeness forms that were not always therapeutic.
Adegbite and Odebunmi (2006) [14]	Nigeria	Recorded consultations in selected hospitals, South-western Nigeria (number not stated in abstract)	Leech (politeness maxims)	Doctors led the exchanges with questions and instructions; politeness maxims were manipulated, and conversational maxims set aside, to reach an accurate diagnosis.
Cepeda (2006) [24]	Chile	17 recorded clinical interviews (psychosocial centres, Valdivia)	Brown & Levinson	The interviewer used positive politeness (address forms, turn control, modal adverbs) and negative politeness (indirect speech acts, modal verbs) to protect the patient's face.
Odebunmi (2008) [6]	Nigeria	30 audio-recorded news-delivery interactions, 15 hospitals	Brown & Levinson	Doctors mostly asserted the condition directly (about 78%), cited evidence (13%) or softened serious or stigmatised diagnoses with veils and hedges (9%).
Iragiliati (2012) [17]	Indonesia	Questionnaire, 66 outpatients	Face / politeness theory	Patients preferred kinship-based terms of address (Bapak, Ibu, Mas, Mbak), with age and marital status shaping the choice.
Ayeloja and Alabi (2018) [25]	Nigeria	25 recorded interactions (University College Hospital, Ibadan)	Brown & Levinson + Leech	Doctors used unredressed FTAs for frank diagnoses and correction, redressed FTAs to allay fears, and the tact, generosity and sympathy maxims to show care.
Lodhi et al. (2019) [4]	Pakistan	10 audio-recorded consultations (5 doctors, government hospitals) plus questionnaire (40 patients)	Brown & Levinson	Bald-on-record dominated (45.4% of strategies), followed by negative (31.1%), positive (19.3%) and off-record (4.2%); doctors displayed power, and many patients were dissatisfied.
Kuna and	Hungary	Questionnaires, 50 patients and 50	Politeness markers / social	Doctors reported using the marker tetszik

Domonkosi (2020) [18]		general practitioners	meaning	far more than patients (90% vs 30%), mainly with elderly patients; it was seen as respectful yet familiar, with age, gender and status shaping its use.
Zayts and Zhou (2020) [26]	China	Interactions between medical professionals and lay users on mobile health apps (size not stated in abstract)	Relational work	App users negotiated norms of appropriate interaction through relational work, and these norms were the basis on which politeness was judged.
Athuman and Tibategeza (2021) [27]	Tanzania	Observation and interviews, four hospitals in Nyamagana Municipality, Mwanza	Brown & Levinson	Positive politeness was the most common strategy and bald-on-record the rarest; inappropriate use of strategies sometimes resulted in impoliteness.
Odebunmi (2021) [28]	Nigeria	Consultations in a doctor-centred and a patient-centred clinic (number not stated in abstract)	Face (socio-cognitive approach)	In the doctor-centred clinic, poor rapport and power-laden strategies silenced patients; participatory talk in the patient-centred clinic improved negotiation.
Olorunsogo (2021) [15]	Nigeria	Audio-recorded consultations, private hospitals (number not stated in abstract)	Other (Yabuuchi hierarchy model; pragmatic acts)	Doctors used five strategies (e.g., diagnostic and familiarisation elicitation, emotive pain alleviation), and patients used complaint focusing; politeness depended on the relationship.
Wei (2021) [29]	China	217 conversations (10 rural doctors)	Leech	Twelve strategies (e.g., greeting, enquiry, praise) that observed or violated politeness maxims made patients more cooperative during diagnosis and treatment.
Barsukova and Rodionova (2022) [30]	Russia	Recorded spontaneous doctor-patient conversations (number not stated in abstract)	Other (speech etiquette)	Politeness went beyond etiquette formulas: euphemism around taboo topics, forms of address, and contact-establishing talk built trust.
Rabab'ah et al. (2022) [12]	Jordan	100 observed emergency-room interactions (208 impolite expressions) by patients and relatives toward staff, including doctors	Impoliteness	Bald-on-record impoliteness was most frequent, followed by negative and positive impoliteness, sarcasm and withheld politeness; dissatisfaction with services drove it.
Clelland and Haigh	Not stated	Pre-registered role-play experiment:	Face/politeness	Under high face threat, letters were longer

(2023) [31]		letters written to a patient or to a family doctor	(experimental pragmatics)	and contained more dispreferred markers, but explicit hedges did not change.
Tian et al. (2023) [32]	China	100 audio-recorded outpatient consultations	Rapport management	Compliments, joking, personal stories, active participation, and kinship-style titles built rapport and encouraged compliance.
Wei and Mao (2023) [8]	China	432 text and audio consultations (TCM)	Rapport management/face	Doctors used small talk both to gather holistic diagnostic information and to boost patients' face for rapport management.
Alduaij et al. (2024) [33]	Kuwait	Patients' evaluations of GP utterances (method and sample not stated in abstract)	Brown & Levinson	Patients preferred negative politeness for instructions, referrals and worrying news, positive politeness for advice and support, and liked the direct approach least.
Fhitri et al. (2024) [34]	Indonesia	Recorded and observed exchanges (7 transcribed), health workers including doctors	Brown & Levinson	Politeness was carried mainly by declaratives; imperatives were softened with respectful address terms and explanations of next steps.
Khan et al. (2024) [5]	Pakistan	88 audio-recorded interactions (7 doctors, government hospital)	Brown & Levinson + Leech	Positive politeness was most frequent, closely followed by bald-on-record; negative politeness was rare; tact and generosity were the most used maxims.
Li (2024) [19]	Not stated	210 teleconsultations (corpus)	Brown & Levinson	Explanations (39%) and treatment proposals (29%) dominated doctors' extended answers; negative politeness was by far the most common strategy (84%).
Mao et al. (2024) [35]	China	148 text consultations (Chunyu Doctor)	Relational work	Doctors met expertise-, experience- and emotion-oriented resistance with interpretives, relationship-supporting moves and, if resistance persisted, imperatives.
Olorunsogo (2024) [16]	Nigeria	Consultations in private hospitals (number not stated in abstract)	Other (Yabuuchi hierarchy model)	Veneration and comprehension strategies were used to negotiate hierarchy; institutional, symmetrical and quasi-institutional politeness types were identified.
Park (2024) [36]	South Korea	Video-recorded primary care visits	Facework	Patients omitted main clauses when

		(number not stated in abstract)		requesting treatment, reducing the face threat and letting the doctor grant or refuse indirectly.
Wang et al. (2024) [7]	China	328 text consultations (andrology, gynaecology)	Politeness theory (markers)	Polite words were the most frequent marker (about 52% of consultations); polite words and best wishes were associated with higher patient satisfaction.
Wang and Bai (2024) [37]	China	36 episodes of the documentary Infinite Life (76 mitigators)	Rapport management	Propositional mitigation dominated (81%), mainly epistemic modals, tag questions and understaters; mitigators served face needs and sociality rights.
Wang and Gao (2024) [38]	USA	Doctor-patient talk in the documentary Boston Med (number not stated)	Brown & Levinson	Doctors used four positive and two negative politeness strategies, with negative politeness preferred.
Zhao (2024) [39]	China	25 episodes of online radio medical consultation	Relational work / politeness	Doctors softened face-threatening disagreements with a range of mitigating forms, which moved talk from divergence to alignment and supported the relationship.
Jiang et al. (2025) [40]	China	Doctors' messages and patients' comments (Dingxiang Yisheng)	Relational work	Doctors combined relational work with diagnosis to regulate patients' negative emotions; patients credited doctors' attitude and communication skills.
Sisay (2025) [41]	Ethiopia	24 audio-recorded ENT consultations (8 analysed in detail), 7 doctors	Brown & Levinson (within CDA)	Doctors controlled talk through interrogatives and bald-on-record directives, while patients took a reactive role and used negative politeness.
Wang and Mao (2025) [42]	China	567 consultations (chunyuyisheng.com)	Face (Brown & Levinson) / rapport	Patients' overinformative replies served grounding, expanding and face-disarming functions that supported informative and harmonious rapport.
Zhao et al. (2025) [43]	China	600 text consultations (120ask.com)	Rapport management	Doctors constructed cognitive, affective, sharing and nurturing empathy as strategies for managing rapport with patients.

When, Where and in What Settings Politeness Has Been Studied

The literature on this topic is recent and expanding rapidly. Only five studies were published before 2010, with three more between 2010 and 2019. In contrast, 26 studies (76%) have been published since 2020, including 18 in just 2023–2025 (see **Figure 2**). Face-to-face consultations continue to be the most common

data source ($n = 18$). Notably, all eight studies of online consultations were published after 2019, with seven utilizing data from Chinese platforms [7,8,26,35,40,42,43]. Additionally, three studies analyzed broadcast documentaries or radio consultations [37–39], three employed questionnaires [17,18,33], and two used elicited or experimental data [3,31].

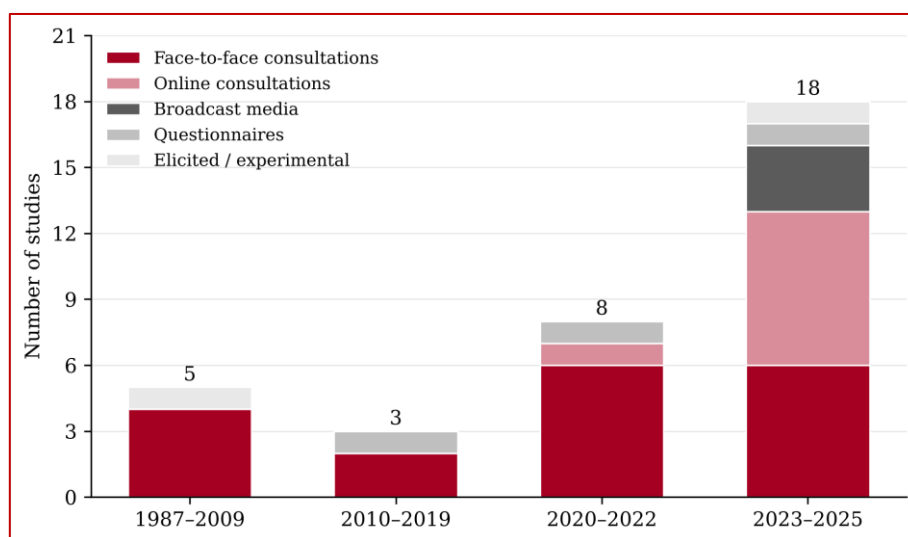


Figure 2: Included studies by period of publication and type of data

The evidence is mainly from East Asia ($n = 12$) and sub-Saharan Africa ($n = 8$), with China ($n = 11$) and Nigeria ($n = 6$) leading these regions (see **Figure 3**). South and Southeast Asia contributed four studies, two each from Pakistan [4,5] and Indonesia [17,34]. Europe provided three studies;

the Middle East, two; and the Americas, two. Three studies did not specify their data sources. Although consultations in South Asia are multilingual, no study examined code-switching between local languages and English as a form of politeness.

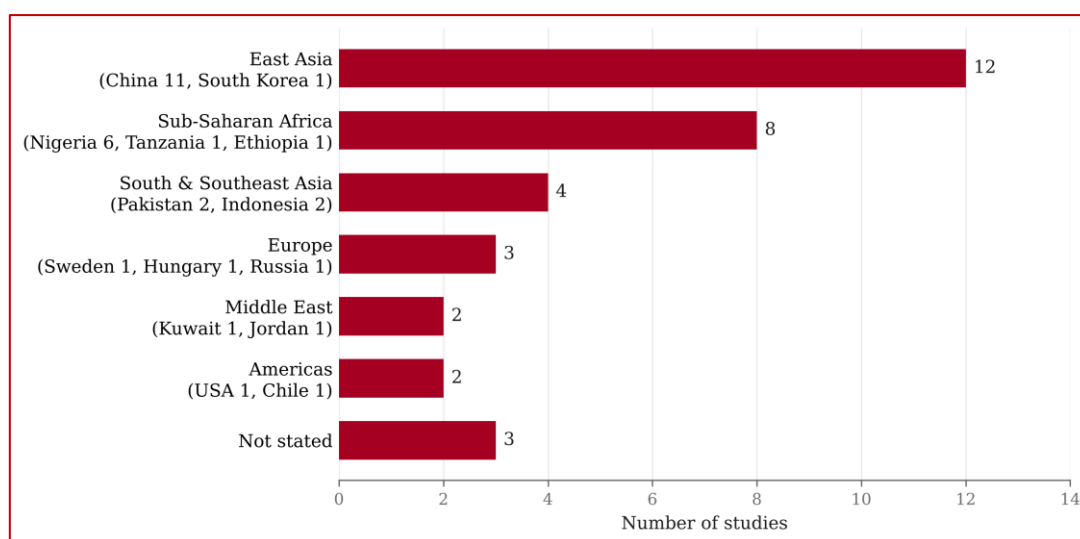


Figure 3: Included studies by region and country of data collection

Most studies investigated doctors' politeness ($n = 17$) or the politeness of both doctors and patients ($n = 12$). Only 5 studies centered on patients

themselves, exploring their preferred terms of address [17], their assessments of doctors' approaches [33], instances of impoliteness in

emergency rooms [12], their indirect treatment requests [36], and face-disarming, over-informative responses online [42].

Theoretical Frameworks and Data

Brown and Levinson's face-saving model, either alone or combined with closely related face concepts, served as the framework for 17 studies. Additionally, two studies integrated it with Leech's maxims [5,25] (see Figure 4). Two other studies relied solely on Leech's maxims [14,29]. From 2020 onward, studies on rapport management (n = 4) and relational work (n = 4) emerged, all based on Chinese data [8,26,32,35,37,39,40,43]. One study used an impoliteness model [12], while four others employed different approaches—such as Yabuuchi's hierarchy model [15,16], a speech-etiquette approach [30], and the social meaning of a politeness marker [18].

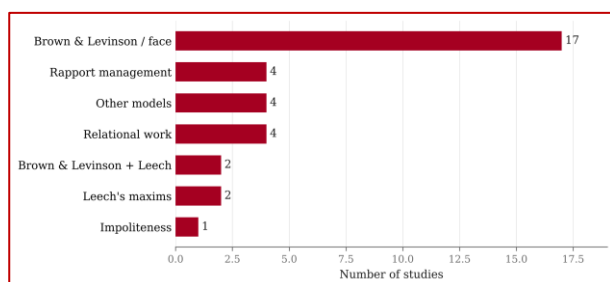


Figure 4: Theoretical frameworks used by the included studies

Data reporting was often limited. In ten studies, the number of consultations or participants was unclear from the abstract or article page. Additionally, several studies that coded strategies did not specify the frequency of each. When reported, sample sizes varied from seven transcribed exchanges [34] to 600 online consultations [43].

Strategies Reported

No single strategy was dominant throughout the literature (see Figure 5). The most common or prominent technique in seven studies was negative politeness or mitigation. This included softening requests during Swedish consultations [2], using hedging and mitigators in documentaries and teleconsultations [19,37,38], easing disagreements on radio [39], managing high face threat in bad-news letters [31], and Kuwaiti patients' preference for negative politeness when doctors provided instructions or news that caused concern [33]. In the teleconsultation dataset, negative politeness made

up 84% of doctors' strategies [19].

Another seven studies highlighted the use of positive politeness or rapport-building strategies. In Chinese outpatient clinics, doctors employed compliments, jokes, storytelling, and kinship-style titles to foster rapport and promote compliance [32]. Online interactions also saw doctors using polite language, best wishes, small talk, and expressions of empathy [7,8,40,43]. Additionally, positive politeness was the most common approach in a government hospital in Mardan, Pakistan [5], as well as in hospitals in Mwanza, Tanzania [27].

Bald-on-record directness was prominent in four studies, all focusing on hospital encounters. In Pakistani government hospitals, it accounted for 45.4% of communication strategies [4]. Ethiopian doctors often used bald-on-record directives to control conversations [41], while Nigerian doctors primarily asserted diagnoses directly [6]. In a Jordanian emergency room, patients most frequently employed bald-on-record impoliteness [12]. Three studies examined deference and terms of address [16–18], with one describing patients' indirect, off-record requests [36]. Another study noted that doctors shifted from supportive to more direct strategies as patients resisted [35]. Additionally, eleven studies reported various strategies without ranking them.

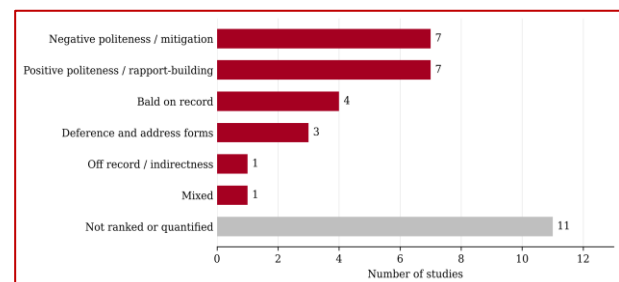


Figure 5: Strategy type reported as most frequent or most salient in each study

Few studies have examined the link between politeness and outcomes. Only one statistically tested this, discovering that polite language and expressions of best wishes predicted greater patient satisfaction in online consultations [7]. Others described outcomes, noting patient dissatisfaction when bald-on-record strategies were prevalent [4], rapport-building efforts that improved treatment adherence [32], and patients attributing reduced anxiety to doctors' relational skills [40].

Discussion

This review mapped 34 empirical studies of politeness in doctor–patient communication published over almost four decades. Three findings stand out.

Politeness in medical encounters varies depending on the context. In hospital consultations in Pakistan, Ethiopia, and Nigeria, directness was most prominent, with two studies linking it to doctors’ institutional power. Mitigation strategies were more common when messages were difficult or when text replaced face-to-face cues, while rapport-building was emphasized in online consultations. Interestingly, two Pakistani studies from different government hospitals reached different conclusions: one found bald on record to be most common, while the other saw positive politeness as prevailing. This indicates that factors such as ward, specialty, and method influence findings as much as national culture. Therefore, claims that a culture or profession is simply “direct” or “polite” are not fully supported by this evidence.

Secondly, the field is generally narrow in scope in most areas and only shows diversity in a single one. Despite being over 35 years old, Brown and Levinson’s model continues to dominate most research, whereas newer relational approaches are almost exclusively used in Chinese studies. This distinction is important because the traditional model views politeness as individual speaker choices, while consultations are co-constructed by doctors and patients. The limited number of studies on patients’ politeness (only five out of 34) highlights the focus on the speaker-centered perspective.

Third, there are notable gaps in the evidence base. South Asia is underrepresented, and multilingual practices—such as switching between Pashto, Urdu, and English during Pakistani consultations—haven’t been studied as politeness strategies. Many studies lacked reports on sample sizes or frequency data, complicating comparisons. Only one study provided statistical measurement of an outcome [7], so assertions that politeness enhances satisfaction or adherence are primarily based on descriptions rather than concrete evidence.

For practice, the review recommends that communication training help doctors adapt their strategies to each task. This could involve being

clear yet gentle when giving instructions, explicitly focusing on rapport when relationships are new or tense, and understanding how patients express face concerns indirectly. For research, similar designs that record actual consultations, report on the frequency of strategies, and connect these to measurable outcomes would transform the current descriptive literature into a solid evidence base.

Strengths and Limitations

This appears to be the first scoping review of empirical politeness research in doctor–patient communication, with all sources verified against publishers or indexing databases. However, the review has limitations. It relied on web-indexed scholarly sources rather than subscription databases like Scopus or Web of Science, and it was conducted in English, potentially missing studies published in other languages or indexed in specialized databases. Although requiring a DOI enhanced traceability, it excluded eight potentially relevant reports, including three based on Nigerian data. Data extraction was often based on abstracts and article pages, and screening and charting were performed by a single reviewer, increasing the risk of errors. The coding of the main strategy simplifies studies that employed various categories and methods.

Future Perspective

Future research should explore regions such as South Asia, the Middle East, and Latin America, focusing particularly on multilingual consultations. It should examine patients’ politeness alongside that of doctors and compare face-to-face versus online consultations within the same healthcare system. Conducting a systematic review with subscription databases and dual screening would be a logical next step. Additionally, intervention studies could test whether training healthcare providers in politeness strategies can influence patient outcomes.

Conclusion

Research on politeness in doctor–patient communication has grown rapidly since 2020, driven by studies of online consultations in China and hospital interactions in Nigeria. Among 34 studies, no single politeness strategy prevails. Doctors vary from being direct in some situations to mitigating or building rapport in others,

depending on the context, platform, and institution. The field mainly relies on Brown and Levinson's model, pays limited attention to patient politeness, often under-reports data, and seldom assesses outcomes. Addressing these gaps, especially in less studied multilingual contexts like Pakistan, could enhance the practical value of politeness research for training doctors and improving patient care.

Declarations

Conflict of interest: The author declares no conflict of interest.

Funding: This research received no external

funding.

Ethics approval: Not applicable; the review analysed published studies only.

Data availability: The full search log, screening decisions and data-charting table will be provided on request.

Use of AI tools: The author used Claude (Anthropic) to assist with the literature search, and Grammarly to correct language. All included studies and references were checked against publisher or database records, and the author takes full responsibility for the content.

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Supplementary Materials

Table 2: Appendix: Search Strings

No.	Search string	Records
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1	politeness strategies doctor patient communication discourse analysis Brown and Levinson journal article	9
2	face-work politeness medical consultation physician patient interaction study	9
3	politeness online medical consultation doctors patients China rapport management study	9
4	impoliteness doctor patient interaction pragmatics study journal	9
5	Leech politeness maxims doctor patient conversation analysis study	9
6	politeness strategies doctors patients hospital Indonesia OR Nigeria OR Jordan OR Malaysia pragmatics article doi	9
7	mitigation directives advice-giving physicians patients politeness Journal of Pragmatics OR Health Communication	9
8	doctor patient interaction politeness Pakistan hospital study Urdu Pashto	9
9	rapport management doctor patient consultation Spencer-Oatey face sociality rights study	9
10	face-threatening acts medical consultation hedging diagnosis doctors politeness pragmatic analysis	9
11	politeness doctor patient interaction Arabic Saudi OR Iraq OR Egypt OR Jordan hospital pragmatics	9
12	politeness doctor patient interaction Ghana OR Kenya OR Cameroon OR Tanzania hospital discourse	9
13	patients' politeness requests to doctors medical encounter pragmatics study	9
14	terms of address doctor patient interaction politeness honorifics study	9
15	politeness strategies doctors patients Chinese hospital outpatient face-to-face consultation discourse study	9
16	politeness strategies doctor patient interaction Indonesia hospital puskesmas pragmatic study	9
17	politeness telemedicine video consultation physicians patients interactional study	9
18	doctor patient communication Malaysia politeness strategies study	9
19	impoliteness patients doctors online health community China pragmatics	9
20	mitigation strategies Chinese doctors online medical consultation Health Communication Mao Zhao	10
21	Robins Wolf 1988 "Confrontation and politeness strategies in physician-patient interactions" Social Science & Medicine 27	9

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