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Vietnamese Perceptions of (Im)politeness through Their Narratives of Medical Encounters with Native English-Speaking Doctors during Postgraduate Study abroad

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Abstract: This study examines how Vietnamese postgraduate students interpret (im)politeness during clinical consultations with doctors in English-speaking countries. Drawing on narrative reflective reports from 14 Vietnamese university academics who completed their doctoral studies in TESOL and Applied Linguistics abroad, the research analyzes participants' retrospective accounts of critical medical encounters in which they evaluated native English-speaking doctors as polite or impolite. Using Braun and Clarke's six-phase framework for thematic analysis, the study identifies key factors shaping these evaluations. The findings reveal that participants associated politeness with behaviors demonstrating care, empathy, respect, and a preference for communication styles that minimize imposition. Moreover, politeness was closely intertwined with perceptions of clinical professionalism, suggesting that professional conduct itself functions as a form of politeness in intercultural medical contexts. Participants' assessments were influenced by Vietnamese cultural values, prior experiences with domestic healthcare communication, and evolving expectations formed through exposure to English-speaking cultures. The study contributes to intercultural pragmatics by illustrating how cultural frameworks shape politeness perceptions in healthcare encounters and offers practical implications for enhancing intercultural communication competence among both EFL learners and healthcare practitioners in English-speaking environments.

Keywords: (Im)Politeness, Intercultural Healthcare Settings, Clinical Consultations, Native English-Speaking Doctors

1. Introduction

Politeness, as a fundamental aspect of human communication, has long attracted scholarly attention across multiple disciplines, particularly within the field of intercultural communication. It plays a pivotal role in fostering cooperative social interaction, maintaining interpersonal balance, and building rapport and trust (Watts, 2003). Conversely, deviations from politeness norms often lead to what Ting-Toomey and Chung (2012, p. 35) describe as "well-meaning culture bumps or clashes," where behavior deemed appropriate in one culture may be perceived as awkward or inappropriate in another, even when no offense is intended. Such misalignments can result in misunderstanding or, in more severe cases, communication breakdown.

In the context of globalization and increasing human mobility, healthcare environments have become markedly multicultural, encompassing diverse languages, norms, and belief systems. Within these settings, effective intercultural clinical communication is vital for minimizing misunderstandings, preventing medical errors, and ensuring equitable health outcomes (Ogbogu et al., 2022). Politeness, in this regard, functions as more than social decorum; it is a professional and communicative competence that helps navigate linguistic diversity, epistemic asymmetries, and culturally contingent expectations (Rossi & Macagno, 2022). Speakers in clinical interactions often adapt their discourse to prevailing sociolinguistic norms, employing affective cues such as softened phrasing or a congenial tone to foster rapport and enhance understanding, while avoiding expressions that could be perceived as dismissive or disrespectful (Ifantidou, 2022). Hence, politeness serves as a strategic resource for managing relational harmony and mitigating potential miscommunication, particularly when directness, valued for clarity in some cultures, is interpreted as rudeness or insensitivity in others (Schnurr & Zayts, 2017).

As a key dimension of pragmatics, politeness is profoundly shaped by culturally specific norms and expectations (Maíz-Arévalo, 2022). When these expectations diverge, they may create what Maíz-Arévalo (2022, p. 588) terms "communicative dissonance", a subtle sense that "something went wrong," even in the absence of overt misunderstanding. This dissonance can generate discomfort, tension, or diminished trust, particularly in intercultural interactions where relational cues differ across cultural frameworks.

Understanding how individuals perceive (im)politeness in professional intercultural contexts such as healthcare is therefore essential, as these perceptions directly influence how communication quality and professional competence are evaluated. Despite its importance,

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politeness in intercultural healthcare remains an under-researched area, even though it constitutes a high-stakes communicative domain where mismatched expectations can affect patient satisfaction, trust, and health outcomes. Previous research in healthcare pragmatics has predominantly examined doctors' communicative behavior or clinical effectiveness, often overlooking patients' interpretations of (im)politeness. There remains a limited understanding of how patients from culturally diverse backgrounds evaluate politeness in medical consultations, especially when navigating linguistic barriers, power asymmetries, and unfamiliar communicative norms.

To address this gap, the present study investigates how Vietnamese postgraduate students, during their doctoral studies in English-speaking countries, perceive (im)politeness in their interactions with native English-speaking doctors. By analyzing participants' narrative accounts of clinical encounters, this study explores how politeness is understood, evaluated, and negotiated in intercultural medical settings. It further seeks to identify the cultural and experiential factors that influence these perceptions, thereby offering insights into communication quality within multicultural healthcare contexts.

Accordingly, the study addresses the following research questions:

1. How do Vietnamese postgraduate students perceive (im)politeness in intercultural medical encounters with native English-speaking doctors during their study abroad?
2. What factors influence their perceptions of (im)politeness in these intercultural healthcare interactions?

2. Literature Review

2.1 Politeness

Politeness theories are generally categorized into two major approaches: universalist and context-sensitive (Al-Duleimi et al., 2016). The universalist perspective is exemplified by Brown and Levinson's (1978, 1987) influential *face theory*, which conceptualizes politeness as a universal phenomenon grounded in Grice's (1975) *Cooperative Principle*. This model emphasizes speakers' intentions and shared cultural norms as the primary guides for polite behavior. According to Brown and Levinson (1987), politeness is closely tied to how individuals manage threats to *face,* defined as the public self-image that individuals seek to maintain during social interactions. Politeness strategies, therefore, reflect speakers' efforts to fulfill two key "face wants": the need for approval and inclusion (*positive face*) and the desire for autonomy and freedom from imposition (*negative face*).

Building on this framework, Ting-Toomey's (1985) *face-negotiation theory* extends the concept of face to intercultural contexts, focusing on how individuals manage face during conflicts and other high-stakes interactions. This theory emphasizes that speech acts such as requests or criticisms may either support or threaten relational harmony depending on cultural expectations. These perspectives have proven particularly valuable in sensitive communicative contexts such as medical consultations, where effective facework and relational dynamics are essential for maintaining trust and respect (Thompson, 2014).

In contrast, the context-sensitive approach, advanced by scholars such as Eelen (2001), Mills (2003), and Watts (2003), challenges the assumption of politeness as a universal phenomenon. It views politeness as a socially constructed and culturally variable practice that is deeply shaped by context, audience expectations, and discursive norms. From this standpoint, politeness is not a fixed property of language use but a *negotiated and emergent process* that unfolds dynamically during interaction.

Research in various Asian contexts supports this view. Studies in Japanese (Ide, 1989), Chinese (Gu, 1990; Hinze, 2012; Xiaohong & Qingyuan, 2013), Korean (Hatfield & Hahn, 2011), and Vietnamese (Pham, 2007, 2008) settings reveal that values such as social harmony, modesty, and respect for hierarchy often take precedence over individual autonomy. These findings underscore that politeness is culturally situated; what is considered polite in one context may be inappropriate in another, depending on local norms, social roles, and relational expectations.

As Spencer-Oatey and Kádár (2021) observe, politeness theory has traditionally centered on communication norms, particularly on how individuals manage face within social interaction. Much of early intercultural pragmatics research focused on identifying similarities and differences in the realization of speech acts such as requests, apologies, and compliments across cultures (p. 48). While these foundational models (e.g., Bargiela-Chiappini, 2003) provided valuable insights, recent scholarship emphasizes the need for more nuanced, contextually grounded analyses of how politeness operates within and across diverse communities and professional domains (Troutman, 2010; Kecskes, 2017; Pham, 2017).

2.2. Politeness In Intercultural Communication

Given the complexity of politeness in intercultural communication, Haugh (2010) noted that, until recently, no comprehensive theory adequately addressed this phenomenon. Similarly, Kecskes (2017) characterized (im)politeness research in intercultural contexts as "an uncharted territory" (p. 8). In response, Spencer-Oatey and Kádár (2021) proposed a holistic framework that conceptualizes politeness as a *dynamic and context-sensitive process* emerging through real-time interaction. In their model, politeness is not a fixed attribute but arises during "evaluative moments" (p. 22), instances in which individuals assess behavior relative to their expectations. These evaluations are influenced by factors such as interactional goals, face concerns, perceived rights and obligations, and moral values, including fairness and care (ibid., p. 81).

Spencer-Oatey (2022) further argues that judgments of politeness are *affectively valenced* and culturally mediated, positioned along a continuum from positive to negative. Such evaluations are shaped by individuals' meaning systems and interpretive frameworks. Moreover, participants tend to evaluate both behavior and the person performing it; when this distinction blurs, judgments can become overly personalized, especially within intercultural contexts where communicative norms differ.

Research on (im)politeness in intercultural settings has largely concentrated on EFL learners, often in academic environments (Al-Khatib, 2021; Murphy & Levy, 2006; Pan, 2025). For instance, building on Kádár and House's (2020, 2021) concept of *ritual frame indicating expressions* (RFIEs), such as *please*, Pan (2025) examined Thai EFL students' use of RFIEs in making requests. The findings showed that learners' politeness choices were influenced not only by their first language but

also by perceptions of social roles and relative status. This underscores the importance of contextual and relational factors beyond simple L1 transfer.

Similarly, Farnia and Yazdani (2018) compared Iranian EFL learners with American speakers and found that the former used more direct strategies in performing the speech act of reminding, while the latter preferred indirectness. They concluded that indirectness and politeness are interpreted differently across cultures, depending on communicative norms and expectations.

Recent studies examining politeness in non-academic intercultural contexts (e.g., Brown & Kim, 2025; Kim & Lee, 2017; Yang, 2021) provide more nuanced insights into how politeness interacts with cultural values, communicative strategies, and language choice. For instance, Pham (2017) explored workplace interactions involving Vietnamese professionals working in NGOs and found that even experienced communicators struggled with cultural expectations that prioritized harmony and emotional reciprocity over efficiency. Despite high English proficiency, these professionals often experienced frustration when their Western colleagues' communication styles did not align with Vietnamese relational norms.

Similarly, Brown and Kim (2025) examined intercultural service encounters among Korean participants in Australia, where both English and Korean were available as interactional codes. Their findings showed that language choice was not merely functional but ideologically loaded: using Korean signified group solidarity and moral alignment, whereas using English was associated with service quality and social modernity. This demonstrates that (im)politeness in intercultural settings is a *contested and dynamic process*, shaped by social meanings attached to language choice.

Yang (2021) also found that disagreement, typically considered a face-threatening act (Brown & Levinson, 1987), can in some contexts serve to maintain rapport and constructive dialogue, as observed in online interactions across mainland China and Hong Kong. These studies collectively illustrate that intercultural communication is a complex environment where (im)politeness is influenced by multiple intersecting factors, including language ideology, cultural values, social roles, and communicative goals.

Accordingly, further research is needed to develop more context-sensitive frameworks for understanding the functions and perceptions of politeness in intercultural communication, particularly in professional, high-stakes domains such as healthcare, where cultural expectations directly affect interpersonal outcomes.

2.3. Politeness In Intercultural Healthcare Contexts

Amid growing globalization, healthcare environments have become increasingly multicultural, as both patients and doctors bring diverse communicative norms, values, and expectations into the clinical setting (Mohiyeddini, 2024). In high power-distance societies, where authority is largely derived from doctors' medical expertise and patients' roles as recipients of diagnosis and treatment (Alkhamees & Alasqah, 2023; Rossi & Macagno, 2022), doctors are often regarded as unquestionable authorities. This perception may discourage open dialogue or shared decision-making (Tegethoff, 2021).

Beyond power distance (Brown & Levinson, 1987), several other factors contribute to challenges in intercultural clinical communication, including the absence of shared background knowledge, contrasting interactional styles between patients and doctors, linguistic and cultural diversity, and institutional barriers within healthcare systems (Alarabi et al., 2024). These factors can lead to misinterpretation or misunderstanding of meaning in intercultural consultations (Kaur, 2022). Language limitations may further exacerbate communication difficulties, even when interpretation services are available (Alkhamees & Alasqah, 2023; Hull & Broquet, 2007). Moreover, mismatched expectations regarding verbal or non-verbal politeness may unintentionally cause offense or breakdowns in rapport, especially during emotionally charged encounters such as diagnoses or treatment refusals (Spencer-Oatey, 2022).

Research shows that communicative strategies aligning with patients' cultural expectations, such as adapting interactional style, using culturally appropriate forms of address, and expressing empathy through both verbal and non-verbal cues, can substantially enhance clinical communication (e.g., Kawathekar & Campbell, 2023; Shirazi et al., 2020; Yan & Li, 2023). These strategies promote patients' sense of safety, encourage the disclosure of critical health information, and improve satisfaction and adherence to treatment, ultimately supporting equitable healthcare outcomes. Conversely, when politeness expectations are misaligned, dissatisfaction, reduced trust, and communication failures may arise, compromising patient safety and leading to unequal treatment (Rossi & Macagno, 2022).

Because communicative behaviors often mirror hierarchical structures, professionals must balance procedural efficiency with relational sensitivity (Spencer-Oatey & Kádár, 2021, p. 112). This balance can be especially challenging in time-sensitive medical contexts, where the urgency of decision-making may produce what Tegethoff (2021) terms a *"rapport-neglect orientation"*, a focus on task completion at the expense of relational harmony (p. 73). Consequently, healthcare professionals should cultivate not only cultural awareness and linguistic competence but also a nuanced understanding of how politeness is constructed and interpreted across different sociocultural contexts (Rossi & Macagno, 2022). Such intercultural competence allows doctors to navigate sensitive interactions more effectively, tailor communication to patients' expectations, and mitigate risks associated with ethnocentrism or cultural stereotyping.

2.4. Vietnamese Politeness

Vietnamese communication practices, deeply influenced by Confucian values, share several characteristics with other East Asian societies (Stadler, 2011). These include indirectness, modesty, emotional restraint, respect for hierarchy, process orientation, and a strong emphasis on maintaining interpersonal harmony, group cohesion, and face preservation (Nguyen, 2016; Tsang & Nguyen, 2020; Van, 2020). Consequently, politeness in Vietnamese discourse is shaped by humility, sensitivity to social roles, mutual face protection, and a preference for emotional reciprocity rather than imposition-free communication (Pham, 2008, 2017).

Humility often manifests through self-effacement and self-downgrading, where individuals intentionally downplay their achievements to avoid appearing boastful (Huynh, 2023). This tendency discourages overt self-assertion, particularly in the presence of authority figures, and can contribute to what Le (2021, p. 57) describes as "generations [that] are only obedient

without their own opinion, so personal development is also inhibited." Vietnamese role-based politeness is most clearly reflected in the concept of *lễ*, derived from the Chinese term *li*, meaning "appropriateness" (Pham, 2008). In Vietnamese, *lễ* forms part of *lễ phép*, "respectful", which encapsulates showing deference to elders or those of higher social status. Accordingly, communication and polite behavior must align with one's social role, thereby reinforcing respect for hierarchy and power distance, which influence both relational dynamics and linguistic choices (Sidnell & Shohet, 2013). In hierarchical interactions, communication typically flows in a top-down direction: individuals of lower status are expected to use honorifics and deferential expressions when addressing superiors (Le, 2021).

The Vietnamese orientation toward *mutual face protection* and acceptance of *imposition* as a form of politeness is another distinguishing feature. Unlike the Western conceptualization of face as an individual possession (Brown & Levinson, 1978, 1987), *mặt* or *thể diện* in Vietnamese refers to a *collective property*. When one person loses face, the social image of their family, group, or community is also affected (Pham, 2007, 2008). Thus, politeness is not limited to safeguarding individual self-image but extends to protecting and enhancing the collective face of all interlocutors involved. When motivated by concern for others' well-being, as in the case of invitations or offers, acts of imposition can, paradoxically, signify politeness and sincerity (Pham, 2008). For instance, Vietnamese speakers may insist that an invitee accept an offer, as refusal could imply detachment or disrespect. This culturally sanctioned imposition reduces the invitee's social burden and reaffirms mutual goodwill.

These characteristics illustrate that Vietnamese politeness, rooted in Confucian and collectivist values, diverges significantly from Western politeness theories (Pham, 2017). Such divergence can pose challenges in intercultural communication, particularly when Vietnamese speakers engage with interlocutors who interpret directness, autonomy, or self-assertion differently.

For Vietnamese individuals living or studying abroad, healthcare encounters often serve as salient sites of intercultural communication. International students frequently face health-related issues that require interaction with host-country medical systems (Tang et al., 2018). However, language barriers, cultural differences, high medical costs, and unfamiliar administrative processes can discourage them from seeking timely healthcare (Brown et al., 2014; Elkhodr et al., 2024; Tang et al., 2018). Within this context, the present study examines how Vietnamese postgraduate students perceive (im)politeness during interactions with native English-speaking medical practitioners while pursuing doctoral degrees abroad. By exploring these perceptions, the study aims to reveal how cultural norms and previous experiences shape communicative evaluations in intercultural healthcare settings.

3. Methodology

3.1. Participants

The participants in this study were 14 Vietnamese scholars who had completed their doctoral studies in English-speaking countries, namely Australia, New Zealand, the United Kingdom, and the United States of America. These countries represent native English-speaking contexts where English is the dominant language in both academic and healthcare settings. At the time of data collection, participants had completed their PhD programs between one month and three years earlier. The duration of their doctoral programs ranged from four to five years, and their ages spanned from 37 to over 54 years.

Participants were recruited through academic and professional networks. Eligibility was determined based on two criteria: (1) completion of postgraduate studies in one of the target English-speaking countries, and (2) willingness to complete an online retrospective report. In this report, participants described medical encounters in which they perceived native English-speaking doctors as either polite or impolite and were asked to justify their evaluations.

3.2. Data Collection Instrument

Intercultural pragmatics research frequently employs elicitation methods such as narratives and reflective reports, which are effective qualitative instruments for capturing subjective experiences and contextual nuances (Kirner-Ludwig, 2022). These methods provide rich, introspective data grounded in personal observation and meaning-making, offering a valuable lens through which to explore complex social phenomena (Pervin, 2024). They are particularly relevant in disciplines where experiential and interpretive perspectives are central, such as education, healthcare, and organizational communication (Haden & Hoffman, 2013).

Accordingly, this study adopted a qualitative research design based on narrative reflective reports to examine Vietnamese postgraduate students' perceptions of (im)politeness in intercultural medical encounters. Although retrospective accounts may be influenced by memory bias, a critical incident approach was used to focus on salient medical encounters that participants vividly remembered. This approach ensured that the narratives captured meaningful, emotionally significant experiences rather than routine clinical visits.

Data were collected using a structured online reflective report consisting of three main sections. The self-report instrument was specifically designed to elicit narrative responses and encourage participants to recall and evaluate real-life interactions with native English-speaking doctors during their doctoral studies abroad. To ensure linguistic comfort and accuracy of expression, the report was written entirely in Vietnamese, allowing participants to articulate their experiences freely and in detail.

- Section 1 gathered demographic and contextual information for each described incident, including participants' age, host country, academic program, duration of residence abroad, and key characteristics of the medical encounter (e.g., healthcare facility type, university clinic or specialist hospital, and purpose of the visit). This section provided the necessary context for each narrative.
- Section 2 prompted participants to describe at least one clinical encounter in which they perceived the doctor as polite. They were asked to recount the situation, including the purpose of the visit, the doctor's gender, prior

familiarity with the doctor, interactional details, their emotional response, and the reasons they regarded the behavior as polite.

- Section 3 invited participants to recount at least one encounter in which they perceived the doctor as impolite. Similar prompts were used to capture their descriptions, reactions, and interpretive reasoning.

By structuring the instrument around both positive and negative experiences, the study enabled participants to engage in critical reflection on their perceptions of politeness and impoliteness within intercultural healthcare settings. The written format allowed them sufficient time to organize their thoughts and provide comprehensive, experience-based accounts. (See Appendix for the full version of the reflective report).

3.3. Data Analysis

This study employed thematic analysis to examine participants' reflections on (im)politeness in intercultural medical encounters. The data were analyzed inductively, following Braun and Clarke's (2006) six-phase framework. Participants' accounts of both positive and negative clinical interactions were first reviewed in detail. Each narrative was carefully examined to identify key segments describing doctors' behaviors that participants perceived as polite or impolite. Open coding was then conducted to capture specific linguistic and behavioral features relevant to these perceptions. The initial codes were subsequently grouped into broader categories that represented recurring themes, reflecting the dominant features participants associated with (im)politeness. This approach helped capture a wide range of authentic intercultural healthcare experiences, while the participants' interpretations provided deeper insight into how these encounters were evaluated and understood.

To ensure the trustworthiness of the findings, several measures were implemented. Participants wrote their narratives in Vietnamese, which enabled them to express complex and sensitive experiences accurately and comfortably, thereby enhancing the credibility of the data. The thematic analysis strictly followed Braun and Clarke's (2006) six-step procedure, and both authors independently reviewed and cross-checked the coding process to ensure dependability. Direct quotations from participants' narratives are presented in the results to provide evidence and strengthen confirmability. In addition, comprehensive contextual information was collected, including participants' age, academic program, host country, type of healthcare facility, and purpose of the visit, to provide a thick description that enhances the transferability of the findings.

4. Results And Discussion

4.1. General Perceptions

The first notable finding is that participants reported significantly more incidents in which native English-speaking doctors were perceived as polite than those in which they were viewed as impolite. Specifically, there were 21 reported instances of perceived politeness, compared to 4 incidents of perceived impoliteness. In fact, 10 participants reported that all doctors they encountered during their clinical visits were polite, with no instances of impoliteness recalled. For example, Participant 1 wrote, "*I could not remember any impolite incident*", while Participant 9 similarly remarked, "*I never had such a feeling because in all the medical consultations I experienced in Australia, the doctors always left me with the impression that they were patient and attentive listeners*". As one participant further commented that if the experiences had been genuinely negative, they would likely have been more readily recalled, given the salience of unpleasant events. This comment aligns with prior research suggesting that negative critical incidents tend to be more prominent in memory (Steven et al., 2020). On the one hand, the findings suggest that participants generally held positive perceptions of the doctors they encountered. On the other hand, the predominance of positive memories in the present study likely reflects the genuinely positive nature of those interactions.

However, the four incidents of perceived impoliteness revealed specific patterns in participants' negative evaluations of native English-speaking doctors. These cases primarily involved situations where participants felt their concerns were dismissed or inadequately addressed. For instance, one participant described an encounter where, after mentioning the use of antibiotics brought from Vietnam, the doctor immediately concluded the consultation without further examination, telling the patient to leave. The participant explained this was perceived as impolite because *"the doctor should allow patients to explain. [He] denied the patient's opinion"* and noted that *"it was very rude"*. Another participant recounted a similarly frustrating experience, citing the same reason when seeking treatment for back pain: "*When asked about the reason for my visit, I said I had a herniated disc. He interrupted and said How could you get here if you had a herniated disc. He didn't ask me more about my previous medical history*". The participant found this approach impolite, explaining: *"The doctor should at least let me explain"*. These negative incidents were marked by participants' perceptions that the medical practitioners failed to listen adequately, displayed insufficient empathy for patient concerns, or made culturally insensitive remarks.

The predominance of incidents in which doctors were perceived as polite, and the fewer cases where they were seen as impolite, enabled the researchers to focus primarily on participants of politeness in intercultural healthcare contexts, as presented below.

4.2. Vietnamese Perceptions Of Politeness In Intercultural Healthcare Encounters

4.2.1. Politeness As Care And Empathy

A recurring pattern involved the use of strategies such as greeting, showing seats, and expressing care and empathy, among which expressions of care and empathy were the most frequently mentioned features in participants' narratives. In this regard, the words most commonly used by participants to describe polite behavior from native English-speaking doctors included terms such as "understanding," "empathetic" (literally *tâm lý* – psychologically attuned), "caring," and "considerate" (*quan tâm*).

Participant 9, who came for a sore throat consultation, described how the doctor greeted her warmly: "*Good afternoon, Ms. […]. Thank you for coming in today. I hope you didn't have to wait too long.*" The participant interpreted the doctor's acknowledgment of her waiting time as a sign of politeness, which contributed to a positive emotional response toward the encounter. The participant also recalled that during the consultation, the doctor also used emotionally supportive language that alleviated her anxiety: "*Thank you for sharing that with me. I can imagine that's been quite uncomfortable for you*". Another participant, who experienced neck and back pain, recalled feeling clumsy while adjusting her chair after being asked, "*Could*

you please move closer and put your hair on one side?". The doctor then quickly reassured her, saying, "*Take it easy. It's just fine*" (Participant 1). This response was perceived as a sign of emotional support and so of politeness. Similarly, Participant 2's narrative reflected her perception of empathy as a form of politeness, as she associated the doctor's gentle manner of speaking and calm tone with alleviating her discomfort from a severe toothache.

The participants also perceived it as polite when native English-speaking doctors demonstrated awareness that the patients were non-native English speakers and accordingly adjusted their speech, modifying their language use, speaking speed to facilitate comprehension. Participant 10, who underwent a compulsory health check for university enrolment, reflected that in her visit, "*The doctor spoke slowly and clearly, ensuring that the patient could understand and respond accurately about their symptoms."* She interpreted this speech modification as a sign of the doctor's politeness, further illustrating her view that demonstrating care in clinical healthcare interactions constitutes politeness.

Many participants also emphasized the importance of emotional care as a form of politeness in clinical encounters. Participant 5, who brought her child for a check-up, appreciated that the doctor engaged in friendly small talk before the examination, which made her and her child feel comfortable. Similarly, Participant 4, who went for a prenatal check-up, noted that the doctor inquired about her overall health over the past month. These small yet meaningful gestures were perceived as expressions of genuine concern and left a lasting impression on the participants. Notably, the doctor was also repeatedly reported to remain calm and unhurried despite busy clinic settings. These emotionally attuned interactions reflected what Spencer-Oatey and Kádár (2021) describe as a rapport-oriented approach that facilitates mutual understanding in intercultural encounters.

Building on this perception of politeness as rooted in care and empathy, behaviors by native English-speaking doctors that were perceived as disregarding Vietnamese patients' feelings and sensitivity were consequently viewed as impolite. For instance, Participant 8 described bringing her son to see a male doctor due to concerns about the child's low weight. After the examination, the doctor joked: "*Look at you! How can you expect your son to be bigger?*". Although the intention may have been humorous and aimed to alleviate worries, the participant found the comment uncomfortable: "*I understood it was a joke, but I still felt uncomfortable because I was genuinely worried about my son's weight.*" This illustrated that, while humor can be a useful communicative tool, if it is misaligned with the patient's emotional state, it may be perceived as dismissive or impolite.

4.2.2. Politeness As Respect

Participants' perceptions of politeness as a form of respect were reflected in their appreciation of native English-speaking doctors' relational presence and their acknowledgment of the information patients provided during clinical encounters. This perceived sense of respect was primarily constructed through the doctor's manner of greeting, the integration of nonverbal cues with verbal communication, individualized attention, and attentive and patient listening.

One participant, who visited for an allergy consultation, reported: "*The doctor stood up, walked to the door to invite me in*." Participant 9, who was experiencing a sore throat, noted: "*The doctor stood up and smiled when greeting me*." Another participant, suffering from back pain, recalled: "*The doctor gently held the chair for me to sit down when asking me to be seated*." These gestures, encompassing both verbal and non-verbal behaviors, were interpreted by the patients as expressions of respect. They were also viewed as indicators of warmth and respect on the part of the doctors.

Participants also perceived doctors as polite when they felt heard and when the information they provided was acknowledged and treated with respect. A participant with a throat infection recalled that the doctor was very polite because she "*listened attentively without interruption*" and "*took detailed notes*", which made the participant feel "*at ease and respected".* Participant 7, who sought medical attention due to rapid weight loss, described how the doctor allowed ample time for her to express her concerns, asked thoughtful follow-up questions, and attentively listened to her account of her symptoms. These behaviours were compared with rushed or inattentive consultations they had experienced with Vietnamese doctors and seen as markers of genuine respect. This aligns with Ifantidou (2022), who argued that mental presence and personalization are key to constructing respect in healthcare interactions.

4.2.3. Politeness As Non-Imposing Communication

Analysis of the narrative data demonstrated clearly to the Vietnamese, communication styles that do not impose on the way the patients provide information and allow free expressions/descriptions are polite. Quite many participants perceived politeness in the doctor's non-imposing manner. Two participants, one with a sore throat and another who took their child to the doctor, recalled being asked open-ended questions such as, "*What brought you here?"* and "*What's the matter?"*. These questions were interpreted as respectful and non-assumptive, allowing patients to freely express their concerns without pressure. One participant explicitly contrasted this approach with typical Vietnamese medical consultations, where doctors often ask direct, problem-centered questions, assuming that patients are ill and in need of immediate treatment. Participant 6, who sought help for joint pain, also appreciated that the doctor presented two possible diagnoses and recommended monitoring rather than prescribing a fixed solution. This approach made the participant feel empowered and respected.

These findings align with Brown and Levinson's (1987) concept of negative politeness, which involves strategies to minimize imposition on the interlocutor. They also resonate with Pham (2014), who observed that Vietnamese doctors, when communicating with outpatients, often use questions literally translated as "*Where does it hurt*?", "*Where is the pain*?", or "*How long has the pain been present*?", thereby unintentionally presupposing that the patient is experiencing some form of pain. This form of questioning implicitly frames the clinical encounter around a predetermined assumption of illness, potentially constraining the patient's narrative and limiting their sense of agency. In contrast, the use of non-imposing communication styles observed in the present study was perceived by participants as a key indicator of politeness and reflective of a more patient-centered approach to care.

4.2.4. Politeness As Being Professional

Interestingly, a majority of participants described native English-speaking doctors as *"professional"* when recounting scenarios in which they were perceived as polite, regardless of the specific situations. Whether referring to the doctors' respectful attitudes, displays of care and empathy, or use of non-imposing communication styles, participants consistently associated these behaviors with professionalism. The term "*professional"* was often introduced at the beginning of their narratives as a framing comment or appeared at the end as a summarizing or evaluative remark, suggesting that participants viewed professional conduct as an integral component of politeness in clinical interactions. This is illustrated in the following account by Participant 13 below:

> *"When I entered the room, the doctor was very polite. She greeted me and asked what brought me there. When I described my symptoms, she listened patiently and spoke clearly for me to understand. She's very professional, very polite.*

A similar tendency was observed across participants' narratives. Their frequent references to professionalism when describing polite behaviors by native English-speaking doctors suggest that, for these participants, politeness is perceived as a key component of professionalism. This pattern indicates a close association, if not an interconnection, between the concepts of politeness and professionalism in the participants' understanding of appropriate clinical conduct. To tease out this relationship more fully, it is important to examine the underlying cultural values that shape Vietnamese expectations of healthcare practitioners' social obligations.

In Vietnamese culture, the medical profession carries significant social weight that extends beyond technical competence. Healthcare practitioners are traditionally viewed as occupying positions of both professional authority and social stewardship, where politeness is positioned not as optional courtesy but as integral to professional duty. The concept of social obligation embedded in Vietnamese cultural values suggests that medical professionals have a responsibility to care for patients' emotional well-being alongside their physical health.

4.3. Factors Affecting Vietnamese Assessment Of (Im)Politeness In Intercultural Healthcare Encounters

A close examination of participants' narratives revealed that, although their assessments of (im)politeness in interactions with native English-speaking doctors were strongly influenced by home-culture norms and values, these assessments were also shaped by two additional factors: their prior experiences with healthcare communication in their home culture and context-based interpretations of politeness.

4.3.1. Influence Of Vietnamese Cultural Values

First and foremost, it is important to highlight that participants' evaluations of native English-speaking doctors' (im)politeness were shaped by Vietnamese politeness values, particularly those emphasizing respect and sensitivity to others' feelings to maintain interpersonal harmony. Moreover, their retrospective accounts and interpretations revealed both direct and indirect references to Vietnamese communication norms, such as attentiveness to social roles and the exchange of emotions. The following account from Participant 13 illustrates this point:

> *"Although he is a doctor and I'm just a patient, his questions [about my exercise and sleep routines] and the way he asked made me feel warm and respected. I understood that his purpose was probably to identify the cause of my issue (neck pain), but as a doctor, he didn't have to ask in such a polite manner."*

Participant 13 reported experiencing recurring headaches and neck pain, which prompted her visit to the university clinic. Her interpretation shows that, while she understood the doctor's questions were medically relevant, she was particularly struck by the politeness with which they were asked. In her view, the doctor's professional status could have justified a more direct or less considerate approach. Her appreciation of the doctor's respectful demeanor reflects a Vietnamese cultural orientation toward role-based communication and deep respect for social hierarchy. The participant's assessment of the native English-speaking doctor as polite clearly stems from her adherence to values deeply rooted in Vietnamese communication. This confirms that, in intercultural communication contexts, particularly in healthcare settings, interlocutors tend to rely on their home cultural values and culturally informed beliefs about politeness to assess the behavior and attitudes of their counterparts.

4.3.2. Prior Experiences With Healthcare Communication In The Home Culture

However, participants' evaluations of the (im)politeness of native English-speaking doctors in intercultural contexts were also shaped by their prior experiences with Vietnamese doctors. This was evident in their frequent and spontaneous comparisons between the examination practices of Vietnamese doctors and those of native English-speaking doctors. Common remarks included statements such as, "*Vietnamese doctors are not so…"* (referring to a perceived lack of patient-centered listening), and "*They tend not to give you extra time*" (implying limited empathy or emotional support). Participants often attributed these behaviors to systemic constraints, noting that Vietnamese doctors *"have a too busy schedule day and night," "many patients waiting to see them without prior bookings,"* and therefore "*tend to rush, especially when your problem is not an urgent issue*." In contrast, native English-speaking doctors were described as *"different*" in terms of providing individualized attention and extra care, which participants perceived as polite.

In addition, as previously discussed, although participants were influenced by Vietnamese role-based communication, which often led them to expect a more direct communication style from native English-speaking doctors as a function of their medical authority, their prior experiences with Vietnamese doctors could also shape their perception of native English-speaking doctors as polite. Specifically, they interpreted the absence of excessive imposition in intercultural consultations as a sign of politeness. Conversely, Vietnamese doctors were perceived as more imposing through their questioning style, particularly when asking questions that implied the presence of lingering health issues, which might have prompted the patient's visit.

This tendency to naturally compare Vietnamese and English-speaking clinical contexts in the narrative data is indicative of a shift in participants' perceptions of (im)politeness in intercultural encounters. While Vietnamese norms allow for a high degree of imposition, especially when it is seen as necessary for the well-being of those involved (Pham, 2008), participants

came to appreciate a non-imposition style of communication in the intercultural context. They felt that this approach supported their sense of agency, enabling them to provide more detailed, less biased information in response to medical questions and fostering a more respectful and empathetic clinical interaction.

4.3.3. Context-Based Interpretations of Professionalism And Politeness

The association between politeness and professionalism, as evidenced in the collected data, suggests that in intercultural professional encounters, such as those in healthcare settings, interlocutors' evaluations of others' verbal and nonverbal behaviors are shaped by their culturally rooted expectations and beliefs about professional communication. Participants' conceptualization of politeness extends to encompass professionalism, and vice versa. This perceived interconnection indicates that, for them, healthcare professionalism includes politeness as an essential component, and politeness is, in turn, evaluated through the lens of professional conduct. In other words, politeness in healthcare interactions is not only seen as indicative of professionalism, but professionalism may also constitute a form of politeness.

Based on the survey data collected, the interconnection between politeness and professionalism is clearly demonstrated through the experience of participant 4 at a specialist hospital in New Zealand. In this specific situation, the participant described:

> *"There was one time when the doctor scheduled a follow-up appointment at 9:30, but I wasn't seen until 10:15. I just made a light comment: there are so many patients this morning. The doctor apologized for keeping me waiting. I said it was okay. In Vietnam, we usually have to wait quite a long time, too. But after the examination, when I went down to see the doctor's secretary to pay for the consultation, the secretary said the doctor had called to say not to charge this patient, along with an apology for keeping the patient waiting."*

Although initially feeling *"quite surprised and felt somewhat guilty",* the participant explained that this action demonstrated politeness because *"the doctor respected the patient" and "knew how to acknowledge his mistakes".* This example vividly illustrates how professionalism is not only regarded as a professional standard but also becomes a manifestation of politeness in the participant's perception. The act of waiving the consultation fee transcends the boundaries of professional obligation, becoming a polite gesture that demonstrates respect and consideration for the patient's feelings. This confirms that in intercultural healthcare communication contexts, politeness and professionalism are not merely intertwined but mutually reinforcing, creating a unified concept of quality healthcare delivery.

5. Future Research And Recommendations

The findings of this study offer important implications for understanding politeness in intercultural healthcare encounters. Firstly, although the participants were experienced EFL teachers who had received formal training in intercultural communication as part of their teacher education programs, they still reported moments of confusion and surprise during medical interactions abroad. This suggests that even individuals who are presumed to possess strong intercultural communicative competence are not immune to challenges in unfamiliar professional contexts. It is therefore essential not only to provide EFL learners and speakers with general intercultural communication training, but also to include modules focused on professional and domain-specific interactions, such as those occurring in healthcare settings.

Secondly, the results demonstrate that individuals' evaluations of politeness are not shaped solely by the immediate interaction but are also influenced by their home cultural values, prior intercultural experiences, and expectations of professional conduct. Engaging in intercultural communication often prompts interlocutors to renegotiate their perceptions of (im)politeness, as observed among the participants in this study. This finding underscores the need for further research on politeness in intercultural professional contexts to better understand the complex and context-dependent nature of (im)politeness and to develop practical, occupation-specific frameworks for communication training.

Thirdly, healthcare professionals working in intercultural environments should recognize that while expressions of care, empathy, and respect are generally perceived as polite and contribute positively to interactions with Vietnamese patients, attempts to build rapport through humor or informal remarks, when guided by culturally specific norms, may not always be interpreted as intended. Doctors, therefore, need to cultivate a higher level of intercultural awareness to communicate effectively with patients from diverse linguistic and cultural backgrounds, even when those patients are highly proficient in English or have extensive exposure to English-speaking cultures.

While the findings provide valuable insights into perceptions of politeness in intercultural medical contexts, they should not be generalized to all populations. The sample in this study consisted of a specific group of highly educated Vietnamese PhD graduates who had recently completed their studies abroad. Future research would benefit from including a broader range of participants, such as long-term residents (e.g., immigrants), business professionals, or international students in other fields, to capture more diverse perspectives and deepen understanding of intercultural (im)politeness across professional and social domains.

6. Conclusions

The findings indicate that Vietnamese PhD students with extended exposure to English-speaking cultures associated the (im)politeness of native English-speaking doctors with the presence or absence of behaviors conveying care, empathy, respect, and a preference for communication styles that minimize imposition. Participants also linked politeness to clinical professionalism, emphasizing the intertwined relationship between these two concepts. Their evaluations of native English-speaking doctors were influenced not only by Vietnamese cultural values concerning communication and politeness but also by their prior experiences with Vietnamese doctors and their expectations within specific clinical contexts.

These expectations, shaped by both cultural and experiential factors, contributed to a shift in participants' perceptions of politeness. Through prolonged exposure to English-speaking healthcare environments, they moved from accepting role-based imposition, common in Vietnamese clinical interactions, to valuing communicative practices that promote patient autonomy, minimize imposition, and strengthen trust and mutual respect in doctor–patient relationships.

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Appendix: Survey Form

(*Translated From The Original Vietnamese Version*)

Section 1: Personal Information

1. Please tick your age group:

☐ Under 30

☐ 30 to under 40

☐ 40 to under 50

☐ 50 and above

2. What postgraduate degree did you pursue abroad?

☐ Master's degree

☐ Doctoral degree

☐ Other: _____

3. Where did you pursue your postgraduate studies abroad?

☐ Australia

☐ New Zealand

☐ United Kingdom

☐ United States

☐ Other: _____

4. During your time abroad, where did you receive medical care?

☐ University clinic/hospital

☐ Specialized hospital

☐ Other: _____

5. Please tick the purpose(s) of your medical visit(s) (You may select more than one option):

☐ Routine health check-up

☐ Sudden/acute/temporary health symptoms (including maternity care)

☐ Emergency situations

☐ Chronic conditions

☐ Other situations

Section 2: Medical Encounters In Which The Native English-Speaking Doctor (E.G. General Practitioner/Physician/Specialist) Was Polite.

Please describe as many encounters as possible.

In this section, please describe a medical visit in which you felt that the doctor was polite.

1. Location: _____

2. Time of day:

☐ Morning

☐ Afternoon

☐ Evening

3. By the time this event occurred, how long had you been living in that foreign country? (e.g., 6 months)

_____

4. What was the reason for your medical visit?

_____

5. How many times had you seen the doctor? _____

6. The doctor was:

☐ Male

☐ Female

☐ Other

7. Please describe the situation (What happened? What did the doctor say? How did s/he behave)

_____

_____

_____

8. How did you feel at that moment?

_____

_____

9. Why do you think the doctor was polite?

_____

_____

_____

Section 3: Medical Encounters In Which The Native English-Speaking Doctor (E.G. General Practitioner/Physician/Specialist) Was Impolite.

Please describe as many encounters as possible.

In this section, please describe a medical visit in which you felt that the doctor was impolite.

1. Location: _____

2. Time of day:

☐ Morning

☐ Afternoon

☐ Evening

3. By the time this event occurred, how long had you been living in that foreign country? (e.g., 6 months)

_____

4. What was the reason for your medical visit?

_____

5. How many times had you seen the doctor? _____

6. The doctor/pharmacist was:

☐ Male

☐ Female

☐ Other

7. Please describe the situation (What happened? What did the doctor say? How did s/he behave?)

_____

_____

_____

8. How did you feel at that moment?

_____

_____

9. Why do you think the doctor was impolite?

_____

_____

_____

Thank You For Your Time And Support.