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POLITENESS STRATEGIES AND PRAGMATIC FUNCTIONS IN DOCTOR-PATIENT INTERACTIONS IN PRIVATE HOSPITALS IN AKURE

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Abstract

This study examined how politeness strategies are constructed and their functions in doctor-patient interactions in Private hospitals in Akure. Although, polite behaviours have been investigated in the field of medical discourse with an emphasis on doctor-patient interaction, this study focuses on private hospitals, with an attempt to magnify the interplay of hierarchy between doctors and patients in private medical practice. Akio Yabuuchi's hierarchy politeness and Jacob Mey's pragmatic act theory were adopted to analyse the data for this study. Audio-taped recordings of doctor-patient interactions in private hospitals in Akure were selected for this study. Five strategies used by doctors are diagnostic elicitation, familiarisation elicitation, emotive pain-alleviation, consultation focusing, and lexical-substitution explanation. The patient-motivated strategy is complaint focusing. The pragmatic functions performed through these strategies are investigating, consoling, focusing, complaining, and inquiring. The negotiation of polite behaviours within social distance and power is evident in the data. Hierarchy in the interactions is relative depending on the type of existing relationship between doctor and patient. This relationship, in turn, determines the type of politeness used. Desires and their gratifications are also negotiated through the politeness strategies identified in the study.

Keywords: Politeness, Hierarchy, Strategies, Medical discourse, Doctor-patient interactions, Private hospital

1. Introduction

Beyond communication and giving information, language is a medium through which behaviours are evaluated and from which desires are conveyed within a given speech community or institution. The two essential capacities of language as per Brown and Yule (1983) are interactional and transactional capacities. The capacity is transactional when language is utilized for information, and it is interactional when language is utilized as an instrument for social connection support. Scholars have investigated the interactional function of language as it fosters social relationship between doctor and patients (Adegbite & Odebunmi, 2006; Černý, 2010; Králová, 2012; Yanti, 2018; Olorunsogo, 2020). This research seeks to add to the body of research that has been carried out on politeness in medical discourse with reference to how polite behaviours are negotiated between doctors and patients.

Language plays an important role in carrying out our various functions as humans in society even in medical practice. Hence, scholars have examined 'politeness' as behaviour in doctor-patient interactions, the term referred to as linguistic politeness **(**Olorunsogo, 2020). In doctor-patient interactions, the use of language can impede or ensure good medical outcomes.

On the one hand, the patient needs to be able to use language to convey his desires to get well as well as to explain the symptoms of ailments. On the other hand, the doctor's effective communication will yield the reward of patient's health improvement. To achieve this reality, it is required to strategise how language is deployed for effective medical output **(**Adegbite & Odebunmi, 2006). This study will evoke the awareness of the medical practitioners to the changing dynamics in the asymmetry between doctors and patients and how the social relationship and power can be sustained through the negotiation of polite behaviours.

2. Previous studies on doctor-patient interactions

The relationship maintained between the doctor and the patients is a vital factor in the outcome of care given. Many studies have been carried out to investigate this relationship as it relates to language use and human behaviours. These studies include, among others, empirical works carried out by Černý (2007), Iragiliati (2012), Odebunmi (2013), and Abdullahi-Idiagbon & Ajadi (2014). In recent times, the traditional model of the doctor-

patient relationship has changed (Kaba & Sooriakumaran 2007). Comparatively, the medical discourse has also been examined.

Ohtaki, Ohtaki, and Fetters (2003) compare doctor-patient communication in the USA and Japan. In their research, they conclude that the similarities of consultative encounters in both countries are on the basis of professional specificity. Akerkar and Bichile (2004) explore the changing dynamics in doctor-patient relationship in the information age. They assert that access to information through the internet has changed the asymmetry in doctor-patient relationship. They explain that patients are more equipped with information like never before, and that has given them strength and increased their power position with the doctors.

Kaba and Sooriakumaran (2007:58) reiterate Szasz and Hollender (1956) demarcations of doctor-patient relationship. The model comprises three components which are: guidance-co-operation, mutual participation and active-passivity. "The activity-passivity and guidance co-operation models are entirely paternalistic and thus predominantly doctor-centred…" Kaba and Sooriakumaran (2007) explain that physicians' dominance has reduced, "thus patient-centred role for the patient who advocates greater patient control reduced physician dominance, and more mutual participation."

Exploring the speech acts performed in doctor-patient communication, Černý (2007) analyses the function and the character of speech acts in doctor-patient interaction of five medical specialities (Internal Medicine, Gynaecology, Paediatrics, Oto-rhino-laryngology, and Orthopaedics) using speech act theory. His research suggests that the asymmetrical relationship between doctors and patients has been pre-served, "…there is a tendency to "reduce hierarchies and renegotiate roles."

According to Černý (2010), searches for communicative strategies of doctors and patients are capable of conveying empathy and trust. He distinguished six categories of questions: agreement, information, commitment, confirmation, clarification and repetition. In his findings, he explains that the most well-known appears in the fact that patient-initiated questions are many in the material he examined. Patients do present questions, and they do so very often. Unlike in previous studies where the event of patient-initiated questions was not important, in his samples patients are active questioners. As a result, patient-initiated questions make up to much more than 6% of the total time reserved for the medical interview.

Iragiliati (2012) investigates greeting in the form of second-person pronoun based on the kinship system in terms of address to show respect as preferred by patients in Indonesia.

The research showed on the importance of the use of greetings in the form of second-person pronoun based on kinship system to show respect preferred. Thus, the patients' choices on terms of address were based not only on age but marital status.

Odebunmi (2013) studies doctors-patients interaction in Southwestern Nigeria. His findings reveal that the social bonding level that exists between a doctor and a patient determines the manifestation of hierarchy or not during consultations. A study carried out by Zibande & Pamukoğlu (2013), examines the possible differences in the number and use of the politeness strategies employed in doctor-patient communication. "The effect of three contextual variables, that is, power, age and gender were also studied to contribute to our understanding of the concept of verbal politeness". Their study affirms the doctor uses 'Bald on Record' strategy with both male and female patients.

Abdullahi-Idiagbon and Ajadi (2014) investigate how politeness is negotiated through the concepts of face and hedging particularly concerning interpersonal interactions or conversations. They compare social distance in doctor-patient and police-suspect conversations using Grice's Conversational Implicature and Brown & Levinson's Politeness Theory. The study reveals that "doctors flout maxims to regulate and mitigate social distance, while the patient uses hedges to curry for the doctor's empathy." Similarly, Swafat and Faiq (2018) explore the usage of hedges in fifteen doctor-patient interactions. The sources of the data for their studies are Platt's Conversation Repair and www.Worth1000.com/contests/doctor-patient. Unlike Abdullahi-Idiagbon and Ajadi's (2014) study, Swafat and Faiq (2018) findings show that in a bid to foster a relationship with patients and to exercise cautions, doctors employ hedges more frequently than patients.

Ayeloja and Alabi (2018) consider the discourse implications of politeness in doctor-patient interactions at the University College Hospital, Ibadan, Nigeria. The data in the study is appraised by a synthesis of Leech's Politeness maxims and Brown and Penelope's Politeness Theory. The study reveals doctors employ politeness maxims and face-threatening acts to allay the fears of patients; express empathy; give counsel; obtain diagnostic information; check unwholesome practices by patients. The discourse functions of the politeness elements include among other, FTA with redress, FTA without redress and tact maxim.

In a pilot study carried out in a private family hospital in Ibadan, Olorunsogo (2020) adopted Brown and Levinson's Politeness theory to identify face wants of patients and politeness strategies used by doctors in three doctor-patient face to face interactions. The study concludes that doctors seem to be friendly towards children by employing positive

politeness strategies, but the bald on-record strategies are employed while interacting with older patients. The kind of face worn by patients is determined by the emergent context.

While some of the aforementioned studies have been able to develop models, strategies and patterns for doctor-patient interactions, others have considered power play and social distance between doctors and patients. This study is not only considering strategies but politeness strategies and their functions in doctor-patient communication. It is also a deviation from the popular Brown and Levinson's theory to account for politeness strategies. With its focus on private hospitals, it supports and disagrees with claims by earlier researchers on the structure and orientation of medical practices regarding doctor-patient interactions.

2.1 Hierarchy politeness

Hierarchy politeness was developed by Akio Yabuuchi in 2006 in a paper titled "Hierarchy politeness: What Brown and Levinson refused to see." Yabuuchi highlighted that Brown and Levinson's politeness theory limited and it does not cater for desires and admiration. Yabuuchi relates politeness to the understanding of human feelings (wants, needs and desires) and the ability to gratify them (either genuinely or not). Yabuuchi accommodated Brown and Levinson's dichotomous politeness (positive and negative) types into a trichotomous framework. The proposed politeness types are hierarchy politeness, autonomy politeness and fellowship politeness. These politeness types are negotiated by the psychological background, social distance and power.

2.2 Pragmatic Act theory

Following the criticisms and limitations of J. L Austen's (1962) Speech Act Theory, the Pragmatic Act Theory was developed in 2001 by Jacob Mey. The Pragmatic Act Theory is otherwise referred to as pragmeme. Mey's Pragmatic Act theory is otherwise referred to as Prgmeme and is an attempt to address the limitations of Austin's Speech Act theory (1962). According to Kadhim (2015:1220), the theory "attains that context is the most important factor in recovering the intended meaning of a speech act, for it is the only factor which could tell about the felicity conditions of speech acts".

While explaining Nodoushan (2013), Kadhim (2015: 1221) writes "pragmemes are speech acts whose meaning can only be figured out through the combination of social situation and linguistics elements utilized…"

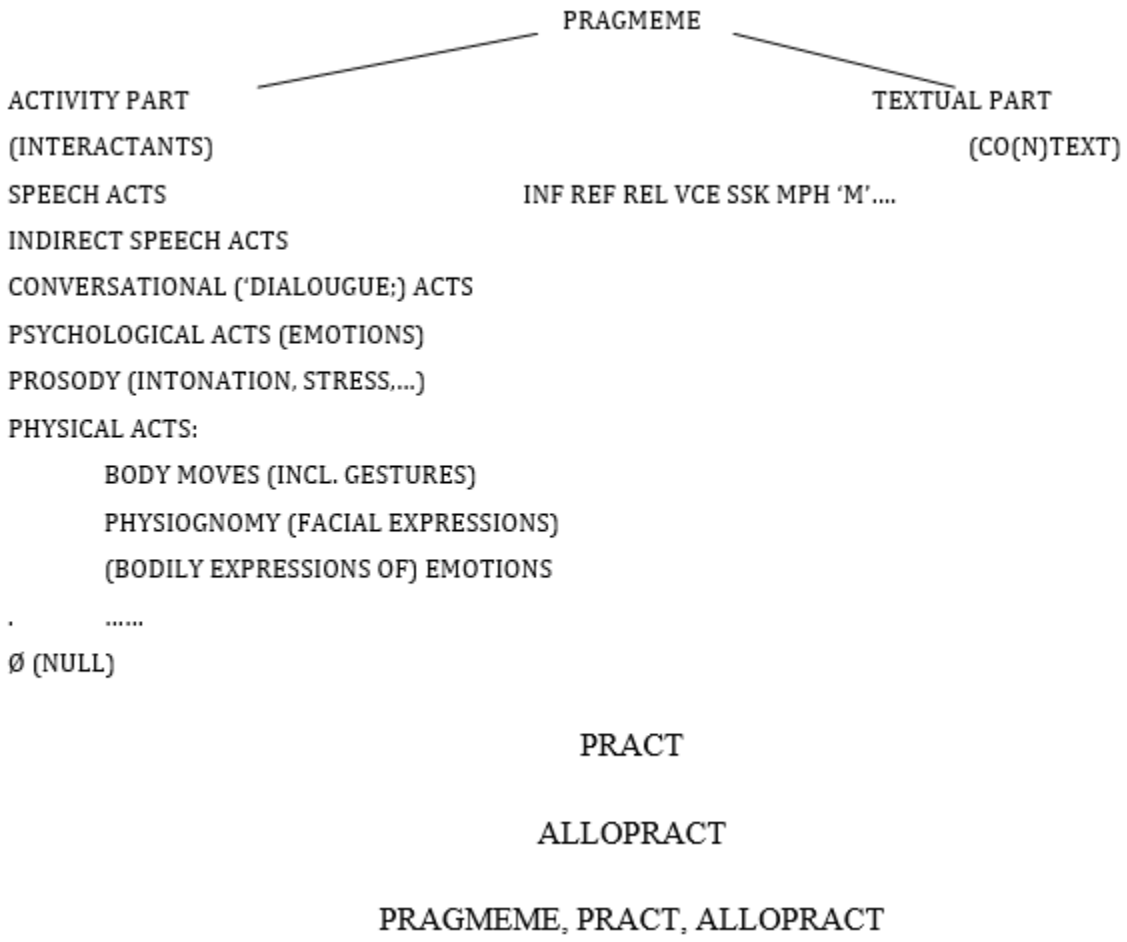

Figure 1: Jacob Mey's (2001:222) Model of Pragmatic Act

3. Methodology

Electronic recordings of fifteen randomly selected face to face doctor-patient consultative encounters in selected private hospitals in Akure formed the data of this study. Akure is

the capital city of Ondo State, Nigeria, it is located in the South-western area of Nigeria with Yoruba and English as the major codes of communication. Many hospitals were approached, but only two hospital managements permitted that research is carried out in their hospitals. Approvals were given by the management of the two hospitals and oral consents of patients were granted. Out of the fifteen audio-taped conversations between doctors and patients, eleven were selected because they are relevant to the study. The eleven audio-taped recordings were transcribed and subjected to a pragmatics analysis.
A qualitative method was adopted for the analysis. While Akio Yabuuchi's (2006) hierarchy politeness was utilized to identify the strategies used in negotiating polite behaviours, Jacob Mey's (2001) pragmatic act theory was utilized to examine the functions of the strategies. The analysis followed a top-down approach, therefore, the selected excerpts were representational.

4. Analysis and discussion

There are strategies used by doctors and patients to negotiate politeness in private hospitals in Akure; the strategies are doctor-motivated or patient-motivated. These strategies are used in negotiating polite behaviours and they perform certain pragmatic functions.

Table 1: Politeness strategies and pragmatic functions in doctor-patient interactions in private hospitals in Akure.

Politeness Strategies and Pragmatic functions			
Strategies		**Practs**	**Contextual features**
Doctor-Motivated Strategies	**Diagnostic elicitation**	Investigating, gossiping	SSK,REF,INF
	Familiarisation elicitation,	Gossiping	SSK, INF
	Emotive pain-alleviation	Consoling	SSK
	Consultation focusing	Focusing	SSK
	Lexical-substitution explanation	Explaining	REF, INF

Patient-Motivated Strategy	**Complaint focusing**	Complaining	REF, INF, SSK

4.1 Doctor-Motivated Politeness Strategies

These are strategies used by the doctor to conduct polite behaviours while clerking patients on his/her health situation. The strategies are Diagnostic elicitation, Familiarisation elicitation, Emotive pain-alleviation, Consultation focusing, Lexical-substitution explanation.

4.1.1 Diagnostic elicitation

The usual conversational structure of the doctor-patient interactions is a recurring question and answer sequence. The doctor asks questions from the patient with the intent of eliciting information about the state of health of the patient. The elicitation strategy favours downward politeness from the doctor to the patient.

Excerpt 1:
Doc: have you been drinking water?
Pat: Enough
Doc: since yesterday?
Pat: I couldn't even sleep
Doc: When did it, you said, okay, was it...Have you been having it before?
Pat: ehm, normally now, it is something that will go for like two times then when you drink water, it stops
Doc: Do you notice that? Is there any drug you are using that you are reacting to?
Pat: That was what somebody told me maybe it is a drug
Doc: So you came before for sore throat?
Pat: No, I have sore throat before, any time I have malaria, sore throat will just be part of it.
Doc: Were you able to sleep?
Pat: No, I can’t sleep, though I took Lexotan
Doc: Open your mouth, bring out your tongue

The doctor in the excerpt above needs to ask questions that will give him the required information, in order to ascertain the cause of the patient's condition, he constrains himself within the system of the institutional politeness. This elicitation procedure takes place in all the doctor-patient interactions as a form of downward politeness, but the doctor is as well gratifying the desire of the patient to get better treatment. The patient does not exercise ego as he accommodates the lack of negative politeness by the doctor through the use of the elicitation strategy.

In Excerpt 1, the pragmatic function of investigating is being achieved. There is a shared knowledge (SSK) about the medical institution between the doctor and the patient. The patient already knows that drinking water can reduce hiccup, so there was no need to ask the doctor why he should take water, it was a remedy he had tried before coming by saying 'enough'. The doctor can then infer (INF) that water may not solve the problem as the patient has already done that. SSK makes the patient infer (INF) that the information requested by the doctor is needed for the doctor to know the cause of his ailment and be able to provide a solution.

Sometimes, questions asked by a doctor may not appear to be related to the health challenges of the patient. Such questions may be pose threat to patients' autonomy face. However, doctors reserve the privilege to ask seemingly unwarranted questions because of institutional roles and hierarchical relationship.

Excerpt 2:

Doc: *So night le ma wa all through bayii?*
So night that you will be all through light
'So, you will be on night shift all through for now?'

Pat: Throughout

Doc: Throughout
bawoni family, bawo le se, igba teba se n dele, awon omo ati awon iyawo yin naa, awon naa a fe lo ibikan.
How 's family, how that do, time you if just getting home, those children and those wife your too, those too will want go somewhere
'How do you manage the family, by the time you get home, your wife and children might want to go out'

Pat: *Ah, mi o l'omode mo*
Ah! I not have infant again
'I don't have small children anymore'

Doc: *Okay, iyawo yin nko, bawo ni iyawo yin se n ri oju yin nile?*
Okay, wife your about, how is wife your do seeing eye your on ground?
'Okay, how about your wife sir, how does she get to see you around?'

Pat: *A roju mi nile, kilode, igba taa n s'omode*
It see eye me on ground, what, when that us not do infant
'She will see me around, why not? We are no longer kids'

Doc: *Kii se oro boya e kii s'omode, so ko i sepe boya iyawo yin wa pelu yin ni, eyin ati iyawo yin jo wa po ni ale, ise yen ti gba gbogbo ale yin*
It's not do word maybe you not do infant, so, it is that maybe wife your is with your at, you and wife your is together at night, work that has taken every night your
'It is not an issue being a kid or not, you and your wife will not get to be together at night, the work has taken over your night'

Pat: K*ii se iyen la n ro bayii doctor*
It's not do that that thinking now doctor
'That's not what we are thinking now'

Doc: *Ki le wi?*
What that say?
'What did you say?'

Pat: *Mo ni kii se iyen la n ro, anything ta ba fe solve, a solve e within the day*
I say it's no do that that we thinking, anything that we if want solve, we solve it within the day
'I said that is not what we are thinking about at the moment, whatever we want to solve will be solve during the day'

Here, the narration of the patient interests the doctor, perhaps he might have more clues to what led to the health problem of the patient. So, he exercises power and asks the patient some questions that are private to him. The superior position of the doctor within the system of autonomy politeness gives him the liberty to ask questions as he desires, which in turn initiates the quasi-institutional politeness. Rather than ask the question about the patient's job as it relates to his health, the doctor asks questions about his job as it relates to his

family. The patient understanding quasi-institutional politeness gratifies the doctor's desire and preserves his ego by providing the information so as to maintain the ego of the doctor.

In Excerpt 2 above, the pract of investigating is manifested through the doctor's interference of patient's privacy strategy. The doctor rides on reference (REF) by referring to the family to be able to know how the patient manages his social life after working all night. Inferences are also made intermittently, as the patient infers (INF) that the question the doctor asked about being around with his wife is targeted towards how able he is to have sex with his wife (based on SSK) considering his work schedule. The inference (INF) made by the patient is wrong, therefore, the doctor reinforces with another input (*Kii se oro boya e kii s'omode)* – that the 'being together' he refers to is not about sex. This leads to another and corrected inference (INF) by the patient that the doctor actually means time for talks and companionship and not exclusively sex.

4.1.2 Familiarisation elicitation

Questions unrelated to the patient's health can also be asked based on the mutual relationship between the doctor and the patient. in this sense, fellowship politeness is co-constructed by both patient and doctor.

Excerpt 3: Doc: Se eyin yii de wa ni Nigeria bayii? E n lo e n bo
Is your this and at in Nigeria now? You going you coming
'Do you mean you are still in Nigeria? You are going to and fro.'

Pat: Olorun ni
God it's
'It is God'

Doc: E sa rora, e se visa fun awa naa.
You please take easy, you do visa for we too.
'Just take things easy, facilitate visa for us too.'

In the above excerpt, the doctor uses the interference strategy to instigate symmetrical politeness. And this is a result of the close social relationship between the two of them. The doctor asks about matters that have nothing to do with the medical situation of the patient,

and the patient accommodated it and enjoys the line of discussion. It cannot be identified who is the superior or the subordinate.

The doctor rides on shared situational knowledge (SSK) to pract gossiping, the patient infers (INF) that the doctor means she has not been around or he has not seen her for some times. The doctor and patient talk about matters that are not permissible in institutional politeness.

4.1.3 Emotive pain-alleviation

Emotive pain-alleviation is a psychologically appeal to the patient, an emotive strategy to make him feel better. Doctors in private hospitals in Akure may allow their humanity to override their strict institutional constraints. Through the emotive pain-alleviation strategy, they expressed human feelings to patients. This strategy is used within the quasi-institutional politeness.

Sometimes, during consultation doctors allow their humanity to manifest, and they empathise with patients as though they feel and can understand the health challenges of the patients as well as the bodily pains they go through. This is done based on the human quality of pain and sickness that doctors share alike with patients.

Excerpt 4: Doc: Open your mouth, bring out your tongue
Pat: (hiccups)
Doc: Sorry

In the above excerpt, the doctor uses emotional-pain alleviation. He switches from hierarchy politeness to fellowship politeness that places him above the patient, by having compassion on the patient. The use of the 'word' sorry in the Nigerian context shows sympathy and human feeling, and with this, the doctor is able to ply fellowship politeness to relate with the patient as equal. The doctor understands the face want of fellowship as it is culturally embedded that one says sorry when you empathise with someone else.

To achieve the pract of consoling through this strategy, the doctor rides on shared knowledge (SSK) to express sympathy through the use of the word ‘sorry’. The doctor tries to do this to show that he is concerned about the patients and also understands that he (the patient) is going through some health difficulties.

4.1.4 Consultation focusing

Doctors can change the subject of discussion at will, to downplay autonomy politeness and to exercise power over and to contain the discussion. Sometimes in the private hospitals in Akure, during a consultation, the patient might have been carried away by a discussion that the doctor does not feel so important, and because of time constraint and the fact that other patients are waiting to see the doctor, the doctor then changes the subject of discussion to what will aide him to assess the patient's health.

Excerpt 5:

Doc: *Awon omo baba to lo nisin bayii, to ba ti de*
Those child father that go in now now, when has that come
'Baba's child that traveled out, whenever he comes back.'

Pat: *Se doctor ni?*
Is doctor it?
'Is he a doctor?'

Doc: *O tun so pe ka fi ise baba sile*
It also say that that we leave work father on the ground
'He even said we should leave his father's work.'

Pat: *E mo pe ko le, won kii paro ni. E mo pe eni to ba je olooto to ba de tun lo s'oun yen, a tete ri ti e se.*
You know that it not hard, go to there that, it quickly see that its do.
They not tell lie is. You know that one that has become honest that has also too
'Don't you know it not difficult, they just don't lie? You know that if anyone who is truthful gets there, he will make it quickly.'

Doc: *kii ti e n se US yen, US, Australia, Canada.*
It's not that it no do US that, US, Australia, Canada.
'We can't even over emphasise US, Australia or Canada.'
S*e e ni any complain loni? ehn?*
Do you have any complain in today? Ehn?
'Do you have any complaint today?'

Pat: *Enu mi sa nikan lo koro*
Mouth my only is bitter
'I only have bitter mouth'

Doc: *Se e ti ma feel any bi pe nkan nbo?*
Do you that have feel any like that something is coming?
'Have you not been feeling that something is coming?'

In the excerpt above, after the doctor and the patient have played on fellowship politeness based on their close social distance, the doctor has to control the conversation and change the subject from personal issue, to what is required in medical consultations. The patient is already enjoying the conversation and mindless of the fact that she has come to the hospital for medical consultation. The doctor, bearing in mind that other patients may be waiting to be attended to, changes the subject by asking the patient the reason for her visit. Here, the hierarchical positioning of the doctor is at play, and he is able to display dominance by focusing on the consultation.

The pract performed by this strategy is focusing. The doctor thrives on of SSK to drive the discussion towards the demand of the consultative context by asking the patient about her complaints.

4.1.5 Lexical-substitution explanation

Lexical-substitution explanation involves replacing a lexical item with a synonymous word so that the addressee can understand what is being communicated. Sometimes, the doctor's professional term may be unintelligible to the patient. Lexical-substitution will be employed to explain to patients. Because of the social distance between the patient and the doctor, patients try to make use of negative politeness upwardly to ask questions about concepts or procedures they do not understand or not familiar with. This lexical-substitution explanation when used, the doctor accommodates the enquiries by the patients and gratifies with relevant answers as applicable.

Excerpt 6: Doc: You have to book your baby o
Pat: Book, what is the meaning?
Doct: Antenatal now
Pat: Okay

In the excerpt above, the patient does not understand the term 'book' in the context from which the doctor has used it. She enquires to know what the doctor means by that. The doctor respecting her ego (and the desire to get the information in order comprehend),

explains using another term 'antenatal' from which the patient is able to infer that the doctor means that she should register for antenatal where the development of her baby in pregnancy will be monitored.

The lexical-substitution explanation in the above excerpt is used to pract explaining. The doctor makes reference (REF) to ‘antenatal’ to evoke the cognition of the patient, thereby, the patient is able to interpret the meaning of “book” through inference (INF) from “antenatal”. The patient, through inference (INF), understands the meaning of ‘antenatal’ so there was no need for a further inquisition.

4.2 Patient-motivated politeness strategy

In private hospitals in Akure, patients make use of certain strategies to initiate specific politeness types. The patient-motivated strategy is complaints focusing.

4.2.1 Complaint focusing

Complaint focusing is used by patients to make doctors mindful of their present health challenges. Patients come to the hospital generally to lay complaints about their health so as to get adequate treatment. In the context of clerking in private hospitals in Akure, it is rather accommodated as upward institutional politeness rather than taken as downplay on institutional politeness. The doctor in the excerpt below initiates fellowship politeness by greeting the patient and asking the patient about his complaints.

Excerpt 7:
Doc: How are you Mr. Jude?
Good morning
What’s the complain
Pat: I came this morning to take my malaria injection. So, just this afternoon, I’ve been fine, just this afternoon I just felt like all my body is stiffening, my back was paining me, and I couldn’t move my legs.

In the above excerpt, the patient refuses to respond to the desire of the doctor for pleasantries. He ignores the greeting initiated by the doctor. The doctor reinforced it with “good morning”, yet the patient refused. The desire of the patient to get treatment overrides

the desire of the doctor to exchange pleasantries. The patient's indifference to the greetings and response to the question of the doctor shows that what he is interested in is to get treatment and nothing else. His silence is a subtle protest against what he feels as irrelevant greetings. Because of the power-play, the patient is unable to outright tell the doctor that he is not interested in the pleasantries, but his message was fully presented through his silence. The doctor has to swop from quasi-institutional politeness to institutional politeness, by switching from greetings to the elicitation of information about the patient's health. This redress is done to fulfil the psychological and emotional demand of the patient. The moment the doctor focused on the complaints, the patient begins to talk and he gives an extensive narrative of his health problem that day.

To pract complaining excerpt 7, the patient rides on REF to refer to the morning and the fact that he has already been treated for malaria, hence, he is implying that he is not supposed to still be having health challenges. The doctor makes an inference (INF) that the patient's refusal is a way to show that he is in serious pain and needs to just make his complaints in order to get possible treatment. When the doctor asked what the patient's complaint is, he quickly responded because the shared knowledge (SSK) is that doctors ask such question to be able to get ways to make patients feel better.

5. Conclusion

Despite campaigns by the World Health Organisation's Universal Health Coverage to strengthen primary health care by adopting patient/people-centered approach even in medical consultations, in the observed private hospitals, doctor-patient interactions still dominantly operate in the doctor-centred approach. This finding is similar to the positions of Unger and Ghilbert (2003) on doctor-patient communication practices in developing countries' private hospitals. One of the manifestations of the patient-centered approach is that power is shared between patients and doctors. In a private hospital, patients pay for all the services rendered by the hospital, nevertheless, the doctors uphold power during medical consultation. Hierarchy in the interactions is relative depending on the type of existing relationship between doctor and patient. This relationship, in turn, determines the type of politeness used. Desires and their gratifications are also negotiated through the politeness strategies identified in the study. In the study, doctors exhibit more strategies to express desires and gratify their wants because they dominate the conversations. The only strategy afforded the patient is 'complaint focusing'. The position of the doctor is evident in the data as being superior to the patient. The prevalent strategy is the 'diagnostic

elicitation' because of the structural pattern of doctor-patient interaction and the need for the doctor to elicit information from the patients so as to get the best treatment possible. In line with the requirement of Universal Health Coverage (WHO, 2016:10) health literacy targeted for patients in Nigeria should be promoted in an attempt to empower patients and transform the health system.

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