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Greetings and Politeness in Doctor-Client Encounters in Southwestern Nigeria

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Abstract

Doctors and clients sometimes experience interactive clashes during hospital meetings in South-western Nigerian hospitals because of their divergent culture-constrained orientation to politeness cues. The goal of this paper is to unpack the discursive elements that characterize interactive confluence and divergence in selected consultative encounters in the hospitals. The findings indicate that institutional and cultural (dis)alignments occur in respect of adjacency and non-adjacency pair greetings. In both greeting types, face support, threat and stasis are conjointly co-constituted by doctors and Yoruba clients within the affordances of the cultural, institutional and situational context of the Southwestern Nigerian hospital setting. Adjacency pair greetings attract mutual interpretings between the parties; interactive disalignments are differentially pragmatically accommodated by doctors and clients. In non-adjacency pair greeting, doctors' threats are co-constituted as appropriate by both parties, the institutional power of doctor and shared Western cultural orientation playing significant roles.

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1. Introduction

Politeness in doctor-client encounters in Nigerian hospitals is associated with the transactional and interactional functions of language (cf. Brown & Yule, 1983, p. 3). Because a typical Yorùbá client likes their face maintained throughout the sequential stages of an encounter, they orient to politeness cues and expect the doctor to do the same both when information is being passed (transactional function) and when social relationships are being cemented (interactional function) albeit with greater tilt towards the latter than the former.

Clients and doctors in Southwestern Nigerian hospitals relate at hierarchic and non-hierarchic levels during consultations, depending on the activity in process and the level of social bonding between them. This is consistent with Coupland, Robinson and Coupland's (1994, p. 89) view that "institutional discourse involves dialectic between institutional (e.g., medical) frames and socio-relational frames for talk". There is the general culture-compliant politeness condition which most interactants, doctors and clients, in the encounters orient to and there is an intimacy further than that which is expressed between select doctors and clients. In other words, doctors and different categories of clients operate at different social and institutional levels with respect to politeness. Because doctors have been inducted in Western values and because clients come to the hospital with culture-influenced beliefs which are almost diametrically opposed experiences, the encounters reveal a number of interactive skirmishes, especially in relation to greetings. However, given that most of the doctors are native to Southwestern Nigeria or a region of the country whose culture converges with the Yoruba culture at a certain level, a degree of alignment with the people's beliefs is sometimes achieved despite the institutional procedural influence. The goal of this paper is to unpack the politeness elements that characterize the interactive confluence and divergence of consultative encounters in Southwestern Nigerian hospitals, during the greeting stage, and the pragmatic strategies deployed by doctors and clients in coming to terms with them.

2. Theoretical Framework

2. 1. Politeness in the Hospital Setting: Situating the Current Research

Studies on politeness in hospital interactions can be grouped into three, namely, works that treat politeness in hospital meetings as an item in a broad research agenda (e.g., Adegbite & Odebunmi 2006; Cerny 2010; Coupland, Robinson, & Coupland, 1994; Odebunmi, 2003; Ten Have, 2002; Webb, 2009); works that examine politeness in the hospital setting with regard to the interactions of professionals other than doctors (Aronsson & Rundstrom, 1989; Backaus, 2009; Brown & Crawford, 2009; Harrison & Barlow, 2009; Grainger, 1990, 2009; Jameson, 2004; Zayts & Kang, 2009); and works that centre exclusively on politeness in doctor-client interactions (e.g., Aransson & Satterlund, 1987; Iragiliati, 2005, 2006; Odebunmi, 2005; Robins & Wolf, 1988).

Works in the last category, which are more related to the current study, with a possible exception of Iragiliati (2006), have largely adopted Brown and Levinson's model of politeness in a direct or modified manner in unpacking relations of politeness between doctors and clients. For example, Aransson and Satterlund (1987) analyze forms of address, request and questioning strategies and feedback patterns in regulating social distance between doctors and clients. Robins and Wolf (1987, p. 217), studying face preservation in doctor-client interactions in the US, demonstrate how Brown and Levinson's theories "can: (1) provide a framework for interpreting communication in general and physician-client interaction in particular, (2) illuminate some of the problems inherent in

doctor-client encounters, and be used prescriptively for teaching students and health professionals how to avoid some communication difficulties".

In Nigeria, very few studies have been devoted exclusively to politeness in doctor-client interaction. Prominent among these studies are Adegbite and Odebunmi (2010) and Odebunmi (2005) which appeal respectively to Leech's (1983) politeness maxims and Brown and Levinson's (1987) face work. Odebunmi (2005) observes that interactions between doctors and clients in orthodox medical practice in Nigeria lean on Leech's tact, generosity, approbation, sympathy and Pollyanna maxims/principles, and Brown and Levinson's bald on record acts, positive politeness and negative politeness. Adegbite and Odebunmi (2010) analyze the deployment of face strategies in orthodox and traditional medical practices in Southwestern Nigeria. They compare the deployment of bald on record acts, positive politeness, negative politeness and off-record politeness in the orthodox and traditional medical settings.

Several of these studies have analyzed interactants' orientation to politeness in the hospital; hardly anyone at the international level and in the particular context of the Nigerian hospital has focused on how cultural and institutional orientations of clients and doctors, at the greeting stage, clash in terms of face and politeness.

2. 2. Language Choice and Interactional Structure in Nigerian Hospitals

In Southwestern Nigerian hospitals, Standard English, Nigerian English, Nigerian Pidgin and Yorùbá (the language of the region) are used. These languages and dialects can be used monolingually or bilingually depending on the local interactional environment. Code-mixing or code-switching is employed by interactants according to the affordances of events and participants (cf. Auer, 1984, 1988, 1995, 2009). Usually, the doctor determines the code of interaction at each encounter although this is sometimes not the case as clients may initiate an encounter in their preferred language and stick with their choice (cf. Odebunmi, 2010). The doctor, equipped with the records of the clients, knows, largely, by the clients' names and states of origin, the language to select. This sometimes fails as certain individuals bear names of Nigerian regions whose languages they do not speak; some clients who bear English names could not speak a word of English. Also, linguistic choices, especially when doctors decide for English, are rated by the approach or appearance of individual clients which is sometimes mistaken, causing doctors to make language correction. An illiterate-looking client, for example, may be a professor, and a literate-looking one may be a snacks seller who speaks no English!

Booking an appointment in advance with a doctor is optional in Nigerian hospitals. Clients can visit any hospital any time of the day they perceive they need the attention of a doctor. On presenting duplicates of their registration documents or announcing their registration numbers to hospital records officers, they are assigned doctors to whom their case notes are referred. All clients have to sit outside the doctors' offices, waiting for their turn. At a client's turn, he/she is summoned through name calling (usually his/her full name without his/her title). He/she is seated, in most cases, on the left side of the doctor's table, and consultation, usually lasting between 3-20 minutes, follows. It should be pointed out that highly placed personalities such as top government functionaries, traditional rulers, top academics and other influential individuals, when personally known to doctors or summoning officers, are sometimes addressed with their titles and given special privileges, dubbed "VIP treatment" in Nigerian English.

Summoning without a title breaks with the Yorùbá socio-cultural norms. According to Adegbija (1989, p. 70), "Nigerians covet and love social, political, religious, national, professional and cultural titles. … a speaker could be considered impolite if he did not address people by their appropriate titles". Except at the pre-adolescent or adolescent stage, an average Yorùbá person likes to be addressed with a title, the least of which is the gender signifier "Mr", "Miss" or "Mrs", in an official setting, a practice not upheld in the hospital.

Interactions in the Nigerian hospital are typically clinical, influenced by the Western permeation of doctors' training. The interactional contents of the meetings are substantially cut down, and emphasis is put on transactional talk (cf. Adegbite, 1991; Odebunmi, 2006), a practice which still drives a good number of the sick among the Yorùbá to traditional healers who orient to their positive face needs and meet their cultural expectations, as will be partially demonstrated in this paper (cf. Adegbite, 1991, 2009; Adegbite & Odebunmi, 2010). Doctors are generally believed to be assuming and cold (Odebunmi, 2013). They are thus placed on a power pedestal and approached with caution and deference. Yet, because many of them are members of the culture, they sometimes relax the clinical stiffness of their talk relationships with clients, and embrace, to some degree, the cultural values of the people. It is interesting though that the doctors' relational style is limited to the institutional environment. They observe acceptable interactional rules outside the consultation frame and at social encounters outside the hospital; otherwise, social sanctions could be placed on them.

2. 3. The Greeting Culture and Interactional Patterns of the Yorùbá

In this section, I attempt a short discussion of the Yoruba greeting culture and the interactional patterns that characterize everyday encounters among the people. The essence is to facilitate access to and provide a cultural context for the conversations between doctors and clients in the recorded interactions analyzed in Section 4 below.

Numbering about 20 million people worldwide, with approximately 18 million of them living in Southwestern Nigeria (Defense Language Institute Foreign Language Center, 2008), "the Yorùbá are one of the leading peoples of West Africa" (Biobaku, 1958, p. 64). Originating from the Near East, they possess a homogenous culture both in their home-base in Nigeria and in the Diaspora, with influences from Ancient Egyptians, Etruscans and Jews (Biobaku 1958, p. 64).

The Yorùbá are extremely culturally-minded people (cf. Babawale, 2008). Among them, "manner 'maketh man'; culture [is] reflected in politeness; and urbanization [breeds] consideration for others and their points of view" (Biobaku, 1958, p. 67). Manneredness is framed in the concept of *omoluabi* (gentlemanliness) (Adejumo, 2010). And being polite is synonymous to behaving in a socially acceptable manner; it also means"… saying the socially correct thing" Fraser (1975, p. 53) or: "…behaving in a socially appropriate manner" (Meier 1995, p. 351).

Greetings, a major way by which the Yorùbá express respect, constitute an integral cultural practice among the people. Hence, the Yorùbá have been rated one of the most respect-conscious peoples in Africa (Adegbija, 1989; Akindele, 2007; Oyetade, 1995). In the words of Elegbeleye (2005, p. 21):

> … in the Yorùbá culture of Western Nigeria, it is culturally mandatory for a child to greet his parents in the morning where they live under the same roof, for a wife to do the same to her husband and her husband's people in the morning, and for the subordinate to do the same to his

> superior each time they encounter one another in a work place….

Adegbija (1989, p. 61), identifying greetings as "major means of showing positive politeness" among the Yorùbá, notes that greetings in Yorùbáland are strategies used by the Yorùbá to attract the attention of a co-interlocutor and facilitate good interactions; that greetings must be initiated by the younger interactant, especially when relating with elders; that most first meeting greetings or reunion meetings are elaborate (see also Akindele, 2007); and that close interactants often extend greetings to relations and associates not present at a current greeting session. With the exception of the first, these cultural practices go contrary to medical institutional norms. Age does not determine the greeting initiator in hospital meetings: the older client may initiate greetings as an index of respect for the institutional power of the doctor. And elaborate and extended greetings are generally absent in doctor-client encounters, but some such practices are sometimes pragmatically accommodated by doctors.

The Yorùbá have greeting forms for all conceivable occasions (Adegbija, 1989; Adejumo 2010; Akindele, 2007; Biobaku, 1958; Oyetade, 1995; Schleicher, 2010). These greeting forms have been classified into three: "greetings based on times, seasons and circumstances (e.g., "káàárò" – Good morning); greetings based on traditional occupation or religion (e.g., "Olókun á gbè ó"- Olokun [the sea goddess] will support you]); situational greetings – greetings for a pregnant woman, greetings for the new mother and the new baby, and greetings for the children of an older person that dies" (e.g., "Kú ìdura"- greetings for the struggle your body [a pregnant woman's] goes through]) Schleicher, 2010, p. 2). This classificatory paradigm, though large, does not encompass the full spectrum of Yorùbá greetings, but it suffices for our purpose in this research.

Utilized in greetings and all forms of talk by the Yorùbá are honorifics and culture-specific address terms, which are referentially and pragmatically used. Yorùbá is a language with a strong honorific attachment, which distributes social labels on the basis of greater or lesser age. "O" or "Ọ" doubles as a second or third person pronoun to index an individual in a lower or equal age bracket with a speaker. "Ẹ" is a second person honorific pronoun, with "wọn" or "àwọn" (they) as its third person counterpart. "Ẹ̀yin" (honoric "you") is contrasted with "ìwọ"- "ọ" (non-honorific "you"). "Àwọn" (third person plural pronoun "they") is an honorific contrast to the non-honorific "iwọ". Sometimes, the choice of honorifics or non-honorifics depends on the nature of a relationship (whether or not interactants are meeting for the first time), status differentials, the level of intimacy and the speakers' personal styles. The alternatives to pronominal honorifics are title prefixing items + surname/first name (e.g., "ọ̀gbẹ́ni Odẹ́bùnmi" (Mr Odebunmi), "Dókítà"/"ọ̀mọ̀wé" (doctor (PhD)), "ọ̀jọ̀gbọ́n" (professor), etc.), marriage-indicative terms (e.g., "ìyàwó" (wife or new wife; "ìyá (mother/wife)), advanced age-indicative terms (e.g., "Bàbá", "Màmá") and consanguinity-indicative terms (e.g., "ẹ̀gbọ́n" (elder brother/sister), etc). In English-medium talk, native English and Nigerian English equivalents of these items are employed, resulting in the emergence of new forms of address terms among the Yorùbá, and many Nigerians, in relatively recent times. Two categories of these are: sect-based relationship items (e.g., "bro" (short for "brother") or "sister") and social distance respect terms (e.g., "Uncle" (any young man), "Daddy" (any married or elderly man), "Mummy" (any married or elderly woman), etc.). None of the items is inherently connected with consanguinity. The first group are labels of address among Christian (and

sometimes Muslim) youths in Nigerian higher institutions of learning; labels in the second group are used in addressing people who are not relations but who have commensurate age with users' relations in the categories under consideration or who simply are married.

Adegbija (1989, p. 68) observes that Brown and Levinson's (1987) negative politeness strategies manifest in Nigerian English, Yorùbá and Ogori as "the appropriate modulation of tone of voice and avoidance of interruption; the use of professional religious, cultural and social titles; and the use of indirectness markers". These findings run in contrast to Nwoye's (1992) claim that Brown and Levinson's negative face is absent in the Igbo (of Nigeria) concept of face. They thus tell the Igbo idea of face from the Yorùbá's, and set up a distinction of face concept in Africa. The point here is that while Africans share several politeness features, a term like "African face" (Grainger et al., 2010, p. 2160) may be too wide to capture the interactional elements.

2. 4. The Face Constituting Theory

The face constituting theory, rooted in constructivist and interpretivist principles, is developed as an alternative to facework theory. It launches an intervention into the limitations of facework which, according to Brown and Levinson (1987, p. 48), is not suited for analysis of jointly produced social interaction. For them, "work on interaction as a system … remains a fundamental research priority, and the area from which improved conceptualizations of politeness are most likely to emerge" (1987, p. 48). To square up to working out these improved conceptualizations, Arundale (1999) takes strides beyond the Gricean principles of communication utilized in Brown and Levinson's theory. He proposes the analysis of face to be anchored to "the Conjoint Co-Constituting Model of Communication", "a broader interactive achievement model of communication" The model implies that the knowledge individuals have of things is co-constituted in the interactions humans have over time, which often result in ideological constructions. Unlike in facework, communication and conversation, in verbal and non-verbal forms, are perceived as discursive achievements rather than a meeting of two interactants' individual cognitive formations. The interpretations, senses or impressions participants generate in the conversations in this "interactional achievement" (cf. Schegloff, 1981) are invariably co-constituted.

Central to the co-constituting model of communication are the concepts of "individual", "interpreting", "expectation" and "producing". The individual produces both linguistic and non-linguistic behaviors; "interpreting" describes "the complex process an individual is engaged in when listening to and producing in talk-in-interaction" (Arundale, 1999, p. 148); "expectation" captures the anticipation evoked by the individual of a pattern or heuristic familiar to them (cf. Levinson, 1995). It manifests in physiological (Allen et al., 1977), psychological (Neisser, 1976) and interactional (Schegloff, 1984) terms. "Producing" "is the individual's generating of sequences of language constituents that comprises utterances to be interpreted by others, both as contributions to and as continuing one's participation in the stream of behavior that is interactional" (Arundale, 1999, p. 130).

Addressing the question, "How do participants achieve face in everyday talk" (Arundale, 2010, p. 2078), Face Constituting Theory's (FCT, Arundale's abbreviation) theoretical premise, Conjoint Co-Constituting Model of Communication, works with three theoretical principles: Adjacency in talk, Recipient Interpreting and Speaker Designing. "Constituting" (rather than "constitution") is Arundale's deliberate choice to describe fluid or progressive interpretings. It separates with the relative permanence suggested by

"constitution" (cf. Arundale, 1999, p. 148). FCT departs "from existing theories in part because [it understands] face as a relational phenomenon" with the parties co-jointly achieving connection face or separation face (Arundale, 2010, p. 2089). In other words, interactants cooperatively construct independence or imposition to face in the context of the moment. FCT locates the commencement of a relationship at the point when interacting parties meet for the first time and start interaction. The relationship stretches across subsequent encounters, maintained actively or modified. "Two individuals may achieve more than one identifiable relationship in the same encounter or in different encounters, and hence may achieve more than one interpreting of face in a given interaction or a series of interactions" (Arundale, 2010, p. 2090). For Arundale, "interpreting" FCT differs significantly from facework because its conceptualization of face is not routed through an individual's public self-image, which could be intrinsically threatening. It conceptualizes face stasis, threat and face support "as evaluations that participants make of the projectings of face that arise as they design or interpret utterances" (Arundale, 2010, p. 2092, cited in Eelen 2001, pp. 109-113).

Face stasis, not included in facework, conceptualizes face maintenance in terms of the routine attention humans accord to face. It thus differs from Brown and Levinson's concept of face maintenance which is conceived in terms of balance restoration, which may not be supported or necessitated in certain interactions. It occurs in a number of culture-specific greeting forms such as the use of T/V in central European languages, formulaic utterances used ritualistically, the use of discernment elements in Japanese, and several other aspects of language use (cf. Arundale, 1999). Threats and supports are conceived of as interpretings co-jointly perceived by interactants as constituting damage and boost to face (cf. Ruhi, 2006).

A cardinal stand of FCT is that stasis, threat and support are "co-constituted in inter-action as participants use language in social relationships" (cf. Arundale 1999, p. 146). In other words, all interacting parties have to co-jointly perceive utterances as stasis, threat or support such that their interpretings are mutually confirmed. In the course of pragmatically negotiating their face preferences, interactants may be constrained to adjust their interpretings in the face of co-interactants' disalignments with their expectation and producing. In the words of Arundale:

> What A had seen as face support could, in the moment of B's utterance, become face threat. In this case, if she is to produce another utterance in the conversation, A will have to utilize the interpreting of her initial utterance (and intention) that was co-constituted in B's responding to her. (p. 146)

3. Methodology

One hundred consultative sessions in 25 hospitals in the six states of Southwestern Nigeria were tape-recorded, and random interviews were conducted with 50 clients on their impressions about the dispositions of doctors to clients. Only 60 of these interactions involving clients of Yoruba extraction were purposively sampled. All the opening portions of the interactions, where greetings occurred, were considered in classifying the politeness features found, but only few instances are cited in the analysis. The transcripts were examined for face and politeness features, the influence of greeting culture on the choice of politeness items and the contexts in which these were used by the doctors or clients, together with the local motivations for the uses. These were complemented with random unstructured interviews with a number of doctors and patients to validate the findings from the interactions. The perspectives gathered were

integrated into the analysis and conclusion. The occurrences of the politeness features were systematically explained with Arundale's (1999, 2006, 2009, 2010) face constituting theory, selected because of its discursively grounded principles. Aspects of relevance theory (Sperber & Wilson, 1986), drawn on to describe or support particular interactive features, were also found applicable at certain points in the analysis. In Section 4, I analyze the data; and in Section 5, I conclude the work. Yoruba texts in the main conversations are in bold fonts; English ones are italicized; translations are in regular fonts.

4. Results

Politeness cues indicating alignments and disalignments between medical and Yoruba cultural norms occur as adjacency and non-adjacency pair greetings in hospital meetings. The individual (doctor or client), their interpretings, their expectations and their producings are conjointly co-constituted against the background of their training (doctors), socio-cultural orientation (clients) and interactional encounters as members of the same society (doctors and clients) evoked at the moment of interaction. I take the greeting forms in turn.

4. 1. Adjacency and Non-adjacency Pair Greetings

In adjacency pair greetings, doctors and clients exchange greeting formulas as prescribed by the institutional and cultural norms. In other words, a greeting proposal is made by either party, and the proposal is accepted through an overt verbal response. In non-adjacency pair greetings, the proposal is made but one of the parties does not accept it. In the two greeting situations, both alignments and disalignments occur, notwithstanding the sync or otherwise between their expectations and interpretings.

4. 1. 1. Adjacency Pair Greetings

Adjacency-pair greetings are largely short, and thus orient more to the medical than to the Yoruba cultural norms which largely prefer elaborate exchanges. However, on certain occasions, the scale bends towards the cultural preference of the client when a relation or acquaintance of the doctor, or an elderly client, is in consultation. Here, the expectation of a relatively elaborate greeting is correctly interpreted by the parties. There are two manifestations of adjacency pair greetings:

1. Greeting proposal made by Client/Doctor and accepted by either party
2. Greeting proposal by Client, ignored by Doctor; Proposal freshly initiated by Doctor, accepted by Client.

4. 1. 1. 1. Greeting Proposal Made by Doctor/Client and Accepted by Either Party

Both medicine and Yoruba culture orient to the practice where greetings are overtly exchanged as indicated by the greeting type in this section. However, medicine, influenced by Western culture and popular for time restraints, subscribes to short greeting exchanges whereas Yoruba culture does otherwise. Yet, both recognize the necessity for greetings. Thus, participants in the encounter play institutionally and culturally acceptable roles, either party sometimes (slightly) adjusting to the preference of the other. The example that follows demonstrates this point.

Ex.1:

(Background: The interaction begins after the client has been summoned into the doctor's consulting room. The client is a regular visitor to the doctor)

1. Pat: **Ẹ káàárọ̀** =
2. (You good morning)
3. (Good morning)

4. Doc: **Ẹ pẹ̀lẹ́**. *How are you*? =
5. (You take sympathy)
6. (You are welcome).
7. Pat: **A dúpẹ́.** *Fine* =
8. (We appreciate)
9. (Thank you).
10. Doc: **Se dada ni? Bawo lara?** =
11. (Is good it? How body?)
12. (How are you? How is your body?)

Client's greeting initiation is presented in Yorùbá, "E káàárò" (line 1), which presupposes a common linguistic background with Doctor. "Ẹ pẹ̀lẹ́" (line 4), a token of Doctor's acceptance of the proposal, which translates as "You are welcome" in English, comes with the Yorùbá honoric "e", an index of Doctor's respect for Client. The interactional expectation of Client is met in part with the response by Doctor in his preferred code (Yoruba), many elite, inclusive doctors, in Nigeria preferring to respond in English to all cues offered in Yoruba or other Nigerian languages that they speak. Doctor switches to English, most evidently as a routine choice (see Odebunmi 2010), to explore the social frame of Client's. With a grip on Doctor's design, she (Client) replies with a code-switched proposition, apparently working within cued interpretings: "A dúpẹ́" and "Fine" (line 7). "A dúpẹ́" is the typical Yorùbá response to "Báwo ni" (line 10), realised in the Doctor's "How are you" (line 12). It is, therefore, the adjacency twin of Doctor's question. Beyond that, Client optimally processes (Sperber & Wilson, 1987) Doctor's "How are you" (line 12) as a probe into her social state; hence, she supplies "Fine" (line 7), which addresses Doctor's probe scope in content and code. In the FCT tradition, Client's "A dupe" and "Fine" are producings stemming from Doctor's psychological and interactional expectations.

Taken out of the interactional context, Doctor's "Sé dáadáa ni" (How are you?), produced at line 10, in a way, passes for a routine face maintenance cue, given its almost needlessness, its English variant having been made earlier to which Client has responded: "Fine". En route to the interactional achievement of the encounter, Doctor, getting entrapped in a relatively elaborate greeting exchange atypical of clinical meetings, interactionally adjusts his phatic producing to match the emerging interpretings aligned to the Yoruba culture. Secondly, given the co (n) textual, "How is your body", Doctor, interpreting Client's "fine" as the termination of the phatic exchange, is already shifting to the medical frame, to which "Sé dáadáa ni" (possibly meaning "Are you fine/Are you doing fine) is meant as a precursor.

Each instance of the greeting gives face support to both parties. For example, Client's "E káàárò", a greeting form prefixed by the honorific, "ẹ" accords respect to Doctor. With an equal honorific, Doctor returns the respect to Client. In a way, the size of the medical business-preceding amenities almost equals that of the type encountered among the Yorùbá when encountering a stranger or a non-familiar person, but not commensurate with the expectation of a typical Yorùbá person when a familiar person is involved in the conversation. This perhaps necessitates Doctor's additional phatic proposition, "Se dada ni?" and a swift switch to the medical frame with "How is your body?", suggesting his unease with amenities and exhaustion of his slot for the interactive business. The talk practice in Yoruba traditional medicine presents a different picture:

Ex. 2:

(Background: The client, a regular visitor to the priest, comes into the priest's consulting room while the latter is in another room inside the house)

1.Obirin: **Ẹ n lẹ́ bàbá o**.
2. (Good day father).
3. Babalawo**: Ìwo ta ni o?**

4. (Who's that person?)
5. Obirin: **Émi ìya Òsogbo ni o**
6. (It's me the woman from Osogbo)
7. Babalawo: **Áà, ẹ mà káàbò o.**
8. (Ah, you are welcome please)
9. Obirin: **Ẹ kúu sẹ́ o**.
10. (I salute to you at work)
11. Babalawo: **Ẹ pẹ̀lẹ́ o**.
12. (Good day to you)
13. Obirin: **Ẹ kúu sẹ́ o**.
14. (I salute you at work)
15. Babalawo: **Ooo, káàbọ̀ o**.
16. (Thanks, you're welcome)
(Adegbite, 1991; Adegbite & Odebunmi, 2010, p. 307)

In this interaction, the priest and the client share deeper culturally grounded expectations than the doctor and the client in Ex 1. The priest connects with the client's face by anxiously welcoming her ("Ah, e mà káàbọ̀" (line 7)), associating with her safety ("Ẹ pẹ̀lẹ́ o" (line 11)) and ushering her into his consultation room ("Ooo, káàbọ̀ o" (line 15)). The client, on her part, reciprocates an equal face support by eagerly declaring her identity ("Émi ìya Òsogbo ni o" (line 5)) and associating with the priest's job ("Ẹ kúu sẹ́ o" (line 13)). The greeting display, most of which is absent in Ex.1, typifies the interactive expectation of a Yoruba person. It is with this orientation that the old woman in Ex. 3 below approaches the doctor in the encounter:

Ex. 3:

(Background: The client, an old woman, is a regular visitor to the doctor. The meeting begins after she has been summoned into the doctor's consulting room).

1. Doctor: **E káàárò**
2. (You good morning)
3. (Good morning)
4. Pat: ( )
5. Doc: **A dúpẹ́**.
6. (We appreciate)
7. (Thank you)
8. Pat: **Omo mi nkọ́**? @@
9. (Child my how?)
10. (How is my child?)
11. Doc: **Dáadáa ló wà, dáadáa laawà.**
12. (Fine he is, fine we are)
13. (He is fine, we are fine)
14. Pat: @@[@]
15. Doc: **E nlẹ́] Ma. Báwo lara yín?**
16. (You take sympathy, Ma. How is body you?)
17. (You are welcome, Ma. How is your body?)
18. Pat: **Too, a dúpẹ́ lọ́dọ̀ Olọ́un**. ( ).
19. (Okay, we thank with God)
20. (Well, we thank God)

Doctor opens the meeting with a greeting proposal, which Client accepts. Although the acceptance of the proposal is not audible, it is obvious by Doctor's response that Client, in addition to the acceptance, places some impositions on Doctor, to which he responds in his next turn, "A dúpẹ́" (line 5). Client goes ahead to invoke further phatic communion by asking after Doctor's children, whom she, tapping into the Yorùbá cultural collectivism, calls her own children. That Doctor perceives this as an imposition is seen in his seeming metapragmatic joker (Mey, 2001): "He is fine, we are fine" (line 15), showing confusion and surprise at Client's extensive greeting, he having only one child, and Client asking after many! His "he" in "He is fine" picks out his only child, and his 'we" in "we are fine", picks out the entire family as the response sometimes is to the greeting form of the type presented by Client among the Yoruba. He then cashes in on Client's space-consuming laughter to separate with her seeming intrusive extensive phatic communion by quickly jumping to the medical frame. His "Ẹ nlẹ́" is a face support device to prevent Client from interpreting his abrupt shift of frame as a threat to her face, Client's verbal behavior and cultural act obviously clashing with the medical interactive norms to which Doctor is accustomed.

4. 1. 1. 2. Greeting Proposal by Client, ignored by Doctor; Proposal Freshly Initiated by Doctor, Accepted by Client.

On many occasions, with respect to the greeting type "Greeting Proposal by Client, ignored by Doctor; Proposal freshly initiated by Doctor, Accepted by Client", Client initiates greeting on being summoned into Doctor's office. This opening verbal gesture is ignored by Doctor who does not provide the expected response, but rather initiates another adjacency pair greeting which Client accepts. This greeting exchange form deviates from the cultural practice among the Yoruba who expect an initiated greeting to be responded to by the target of the greeting except they are not getting along well with each other. In interactions where this situation occurs, the adjacency-pair greeting orientation of a Yorùbá person misses a bearing. It is telling that the data did not reveal occasions where Doctor's proposed greeting is ignored by Client. This confirms the dominant symmetrical relations reported in the literature on doctor-patient interaction, with interactive and professional power placed more with doctors (cf Odebunmi forthcoming)

Ex. 4.

(Background: The consultation with the client, a regular relatively elderly visitor, begins after being summoned)

1. Pat: *Morning*=
2. Doctor: *How are you? =*
3. Pat: *Fine si*r::=

Client's "Good morning" (line 1), normally should be replied either with "Good morning" or "You are welcome" (or any other culturally acceptable formula) by Doctor, following strictly the Yoruba greeting cultural script. But Doctor, selecting none of these, refreshes the greeting routine with "How are you" (line 2), which, seeking to probe into Client's social wellbeing, seats Doctor on a power pedestal, working within the Yoruba cultural ideology. An utterance such as "How are you" ("Bawo ni") without a grammatical or lexical honorific, (whether in English or Yoruba discourse) is considered a reserve of a superior agent. The interaction produces a slightly complex situation: Doctor perhaps does not have his interactional expectation met in Client's initiating move which comes with no lexical honorific. One explanation for this might be Client's greater age, which she brings into the consultative session. Doctor, suffering face threat, as a result of what could be termed, "institutional interactive face damage", expecting as he is wont to a honorific, overrules Client's greeting proposal and disprefers her expected face support by saying "How are you", also without an honorific. In other words, he interprets Client's culturally-imbued face support as a threat contrary to Client's psychological and interactive expectation. Thus, Client's provisional interpreting is not confirmed by Doctor. In the words of Arundale (1999, p. 146), "What A had seen as face support [has], in the moment of B's utterance, become face threat". Client, perhaps, interpreting the utterance as a threat, drops her cultural face for the interactive reality of the consultative session, conjointly co-constituting face maintenance with Doctor in a power-sensitive context, and inserts a lexical honorific in her follow up response: "Fine sir" (line 3). This is consistent with FCT's principle that recommends pragmatic revision on the basis of a recipient's interpreting: "… if she is to produce another utterance in the conversation, A will have to utilize the interpreting of her initial utterance (and intention) that was co-constituted in B's responding to her" (Arundale 1999, p. 146).

4. 1. 2. Non-adjacency Pair Greeting

Non-adjacency pair greetings reveal only one proposal format: "Greeting initiated by Doctor, intervened by Doctor's questing into

Client's identity or broad request, which overlays Client's pair of adjacency". As will be shown below, with this format, Doctor obstructs the greeting procedure, and overrules Client's preference, the latter's cultural expectation notwithstanding.

Ex. 5:

(Background: The meeting opens with the client's response to the summons by the hospital attendant. The doctor opens the phatic phase of the encounter as she moves towards her seat. She (a relatively elderly client) is a regular visitor to the doctor).

1. Pat: *sir* (.)
2. Doctor: *How are you? What is your name?* =
3. Pat: *I am* ( ) =
4. Doctor: ( ). *Okay*, **ẹ pèlẹ́. Báwo lara yín**? –
5. (Okay, you take sympathy. How body you?)
6. (Okay, how are you? How is your body?)

The meeting begins with Client's response to invitation for consultation with Doctor. Unlike Client in Ex. 4, who employs an elongated "sir", Client here utters the deference token normally. Doctor proposes greeting: "How are you?" (line 2), but also asks for Client's name, a sudden abrogation of Client's turn right. Client, in her ultimately allocated turn, interprets Doctor's producing as privileging the second interrogative, which she reckons preempts a medical encounter, showing a pragmatic adjustment to Doctor's unilateral ordering of the interaction, conscious of Doctor's institutional power. Here, Doctor seems to underrate the impact of Client's response by overlaying Client's acceptance, and thus prioritising identification which usually dovetails to medical issues. This way, Doctor places little value on Client's group face (Nwoye 1992). After Client has provided her name, Doctor repeats honorific greeting ("E pele" (line 4)), a support for Client's seeming threatened face, ostensibly realising that Client, given her greater age, had merely accommodated his institutional imposition, and moves swiftly to the medical frame (Báwo lara yín?" (line 4)), but he does not give a response turn to Client. This exercise of power has been extensively discussed in the literature on Doctor-client interaction (Fisher & Groce, 1990; Heritage & Maynard, 2006; Maynard, 1991, 1992, 2003, 2004; Mishler, 1997; Odebunmi, 2008; Perakyla, 1998).

Doctors, sometimes, prevent clients' responses to their greeting proposals by making a broad request regarding client's condition, or providing an assessment of their conditions.

Ex. 6:

(Background: Consultation begins after the clients, who are not new visitors, have been seated).

1. Doctor: *Good evening. What's wrong with your baby*?--
2. Father: *It's cold and stooling* [diarrhea], -- *and the stooling is frequent* (.)

After making a greeting proposal ("Good evening" (line 1)), Doctor requests for the medical ground on which the clients visit ("What's wrong with your baby?" (line 1)). The request interactively supersedes acceptance of greeting proposal. The clients thus opt for the bit of Doctor's utterance which Doctor prioritises.

In the account of face work, Doctor's "Good evening" (line 1) is a cultural and institutional act which provides positive politeness connection with Clients' face. In the Yoruba culture, Doctor's barring of clients' response to the proposed greeting constitutes a disalignment with acceptable interactional norms and a potential threat to their face. However, working with the discursive contextual provisions of FCT, it can be explained that this disalignment is not considered a threat by both the incipient and recipient interactants, as clients' psychological and interactive expectations match perfectly with the medical business privileged by

Doctor, considering their face as having been sufficiently maintained by the institutional, rather than cultural, politeness experienced by Doctor. This interpreting differs from that in Ex. 5 above where Doctor had re-introduced greeting with face support considering his failure to allow the materialization of Client's psychological and cultural expectation. In this interaction, no such greeting occurs. The couple being young and highly educated obviously belongs in the generation of Nigerians who are highly influenced by the Western culture like most doctors. In the moment of the interaction, "Good evening" said by Doctor is conjointly interpreted as stasis, a mere routine, rather than an interactively demanded choice. Hence, the conversation continues without any intrusive phatic interjections, implying that no interactive clash is co-constituted.

5. Discussion

I have argued in this paper that the politeness cues preferred in doctor-client interactions in Southwestern Nigeria establish interactive alignments or disalignments with the Yoruba cultural norms at the greeting stage of the meetings. These interactive features occur in respect of adjacency and non-adjacency pair greetings. In the former, face support, threat and stasis are conjointly co-constituted by doctors and Yoruba clients within the affordances of the cultural, institutional and situational context of the Southwestern Nigerian hospital setting. In adjacency pair greeting, partial interactive alignments, achieved on the basis of face support, with mutually matching interpretings, occur in the interactions when considered strictly from the Yoruba cultural perspective. Interactive disalignments in respect of greeting length are pragmatically accommodated by doctors; those in respect of ignored attention are accommodated by clients. In non-adjacency pair greeting, doctors' largely potentially threatening subduing of clients' responses, when considered from the Yoruba cultural point of view, is co-constituted as appropriate by both parties, the institutional power of Doctor and shared Western cultural orientation playing significant roles.

Outside the hospital consultative setting, alignments or disalignments with appropriate greeting formats take a serious dimension. Greetings ignored or overlaid may precipitate some skirmishes or other forms of social instability. Terms, honorific or otherwise, are selected relative to age or status of incipient and recipient interactants. Thus, doctors, irrespective of their professional pedestal have to be subjected to the cultural precincts of the larger Yoruba society. This picture shows the level of accommodation and cultural compromise clients orient to in the hospital where greater age or status does not necessarily constitute an index of politeness from doctors. Much of the data reveal that doctors' choice and interpretation of politeness cues in Southwestern Nigerian hospitals are constrained more by the medical institutional norms than by the Yoruba cultural values.

Random unstructured interviews conducted with clients reveal that many doctors are considered arrogant, rude and clinical, but that clients have had to take whatever disalignments experienced in the consultative encounters in the exchange, as appropriate, for effective medical interventions. Invariably, client retention in the hospitals is not based on social acceptability of the medical institution but rather on its professional competence. This provides the interpretation that a more effective medical alternative may break the monopoly of Western medicine in Southwestern Nigeria. The current large patronage enjoyed by (modern) traditional medicine in Nigeria is a good testimony (cf. Adegbite, 1991; Adegbite & Odebunmi, 2010; Odebunmi, 2012). This behooves doctors to orient more to the cultural face needs of the

people, especially at the greeting stage, for more rewarding consultative encounters.

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