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# Impoliteness Strategies in Nurse-Patient Interactions in Two Public State-Owned Hospitals in Delta State: A Focus on Pre and Post Doctors' Consultation Encounters

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## Abstract

Impoliteness is a negative language behaviour which causes dissatisfaction in communication. The patients who are the judge as to whether hospital communication is dissatisfactory or not, usually feel threatened by nurses' impoliteness. Therefore, this study examined impoliteness in nurse-patient interaction in Asaba Specialist hospital and General hospital, Okwe. The aim is to identify and discuss the impoliteness strategies and their frequency of occurrence as used by nurses and patients in pre and post doctors' encounters. The theoretical underpinning for the study is Jonathan Culpeper's (1996) theory of impoliteness. By a direct observation, the study recorded the natural occurring conversations of nurses and patients in both hospitals. Through a purposive sampling method, interactions with elements of impoliteness were identified and isolated for further examination. The isolated data was further triangulated through a qualitative descriptive method of analysis. The findings showed that the patients and nurses examined use positive impoliteness strategy, negative impoliteness strategy, sarcasm and withhold politeness strategy with bald on record as the most frequently used. The study recommended that nurses should minimise the use of obvert impoliteness in patients'

health care interaction and embrace strategies that minimises face attack.

**Keywords:** Impoliteness, Nurses, Interactions, Patients, Consultation, dissatisfaction

## Introduction

Patients come to the hospital for consultation with varied emotions; covered in this category is feeling well or feeling unwell, which is revealed in a language. Little wonder, Fromkin et al (2011:284) says: "to understand our humanity; one must understand the nature of language that makes us human. Therefore, language is pivotal in human existence. It is essential for providing quality nursing or health care. As a matter of fact, the relationship between language and health is a convoluted and complex interlock of means and matter, in the sense that if the linguistic integrity of medicine is withdrawn, the latter is uncertain thus, the interest of linguists in discourses of health.

Nurses, patients and other language actants in the hospital often engage in a lot of activities. The most crucial of all the activities is interactions: they talk, enquire, consult, advise and ask questions for better health outcome. As a result, impoliteness perhaps, may be a noticeable feature of these interactions. Despite the salience of impoliteness events and public discussions surrounding impoliteness, a gap exists between theoretical frameworks and actual language use. Although, Lachenicht (1980) provided an early comprehensive paper on impoliteness that addressed communicative issues, it did not spark significant research in the field. Instead, research focused on politeness, particularly within sociolinguistics and pragmatics. Notably, the dominant politeness theory, Brown and Levinson's (1987) model, aimed at mitigating threats to face and largely ignored impoliteness. Jonathan Culpeper's (1996) study on impoliteness, however paved the way for many researchers to delve into the field of impoliteness. Craig

et al. (1986) argued that a comprehensive account of interpersonal communication should consider both cooperative (polite) and hostile (impolite) communications as they both exist alongside.

Impoliteness has often been seen as the opposite of politeness. Culpeper (2020) in a keynote address described impoliteness as: "a language of conflict, which has the tendency to incite anger or hurt". It is a negative language behavior that is usually disapproved in any society. Patients' assessment of nurses' language behavior is important to understanding patients' health and care. A positive language behavior could be judged as a satisfactory customer service interaction while a negative language behavior may be judged as unsatisfactory. Pearson (2003:69) succinctly, states that: "The customer is the ultimate judge as to whether customer service interactions are satisfying or not". Impoliteness among language actors in the hospital setting can hinder good health outcomes, in the sense that old ailments may get worse and new ones may emerge. Patients, when they feel disrespected and hurt, could become dissatisfied with health care process and perhaps, dismiss health advice, downplay the consequences and disregard the important role of the nurse in realizing health goals.

Nurses are the integral part of patient health care. They perform key roles in doctors'' pre- and post-consultation encounters. They are present when patients are in their most vulnerable states, for instance, when patients lay helpless on the hospital bed. The nurse becomes the patient's voice and advocate—the person who understands the patient the most, constantly checking on the patient, and meeting his/her most basic needs. The nurse is the perfect interpreter; he or she listens to the patient to find out what is needed and relays that to the rest of the health care team to provide patient-centred care. Nurses help patients on their way to recovery and are also present when the long-anticipated discharge from that hospital bed finally arrives. Their initial meeting (pre-

doctors' consultation) with patients entails taking patients' vital signs, preparing and sending them to meet with the doctor while the post-doctors' consultation meeting involves the nurse coordinating the patients' health care by working and collaborating with other health care professionals. A unifying factor and a necessary component in pre and post doctors' encounters is language. Little wonder Odebunmi (2008:13) asserts that: "language bears the entire burden of hospital consultation".

Language is the key factor in hospital interaction. Without language, it may be impossible for the nurse to coordinate patient's care. Thus, the need to constantly examine language behaviours in the hospital. In the light of this, the present study beams its search on impoliteness in nurses-patients interactions in two public hospitals in Anioma speaking area of Delta state, with a focus on pre and post-doctors' consultation encounters. The aim of the study is to identify impoliteness strategies and discuss their realization in the interactions of nurses and patients in Asaba Specialist Hospital and General Hospital, Okwe. It is hoped that the findings from this study will help the managements of the hospitals examined to understand the pragmatic nature of the ensuing conversations between nurses and patients and improve on their curriculum.

**Statement of Research Problem**

The problem of this study is impoliteness in nurse—patient interactions in two public state-owned hospitals in Delta state. Communication skills and medical ethics are taught to medical practitioners at medical colleges, yet patients complain of nurses' impoliteness in government hospitals in Delta state. Although, a number of studies (Olorunsogo, 2021: Odebunmi, 2011, 2013 and 2005) has been conducted on medical discourse in some Western Nigeria states to examine politeness, there is also the need for similar studies to be conducted in hospitals in Delta state.

**Theoretical Framework**

The foundation of this study rests on Jonathan Culpeper's (1996) impoliteness theory. According to Culpeper, impoliteness comes about when (1) the speaker communicates face attack intentionally or (2) the hearer perceives and/or constructs behavior as intentionally face attacking or a combination of 1 and 2. For Culpeper, impoliteness is co-constructed by participants in an interaction because it is not unintentional. He further proposed five strategies upon which speakers use to make impolite utterances. They are as follows:

**Bald on Record Impoliteness:** This impoliteness strategy is direct, obvious, unpretentious and daring. It is used by speakers to attack addressee's face in a straight forward, obvious, unambiguous and brief way in a situation where the face is at stake

**Positive Impoliteness:** Culpeper describes this strategy as that: "used to damage the hearer's positive face want (his desire to be accepted). Positive impoliteness undermines addressee's desire to be loved, approved of, respected and appreciated by others." Moreover, realization of positive impoliteness is a form of: ignoring or snubbing the other; denying common ground with the hearer; selecting a sensitive or undesirable topic to talk about; using inappropriate identity markers; being disinterested and unsympathetic with the hearer; looking for disagreements; using obscure language and inserting secretive words within the discourse and using taboo words.

**Negative impoliteness:** This is the use of strategy to attack the addressee's negative want. It involves the following sub strategies: scorn, frighten, ridicule, invade the hearer's space literally or metaphorically**,** condescend and belittling the other.

**Sarcasm or mock impoliteness:** This is a face threaten performed using politeness strategies which are clearly insincere. The user

praises the target but the intention is to mock. Sarcasm is clearly the opposite of banter.

**Withhold politeness:** This strategy occurs when the speaker does not perform politeness, where it is expected. The realisation of withhold politeness is keeping silent and failing to thank.

Culpeper's framework is considered one of the most comprehensive attempts to theorise impoliteness, some scholars nevertheless, have expressed dissatisfaction with the concept of a strategy and its scope. Nwabuwene (2017:8), quoting Ige, mentions that Eelen, Harris, and Mullany have criticized it for it's limited universal application. They argued that the shortcomings found in Brown and Levinson's model of politeness, such as the overgeneralization of Eurocentric norms and the limitation of using 'face,' also apply to Culpeper's theory of impoliteness, as it functions as a parallel framework.

However, Koh Adelina, as cited by Nwabuwene, contends that Culpeper's model is plausible because it aligns with classical and discursive approaches to impoliteness. The classical approach emphasizes shared conventions of meaning, while the discursive approach focuses on the interpretations made by actants themselves. Culpeper's theory bridges these contrasting views. Undoubtedly, Culpeper's studies on impoliteness have greatly contributed to the understanding of this phenomenon. Therefore, Culpeper's theory has been adopted for this study due to its detailed specification of impoliteness formulae in English.

## Empirical Studies

### Studies in Hospital Discourse in Nigeria

Quite a number of linguistic researches have been carried out on medical discourse in Nigeria, to examine language behaviours of actants. Such studies as: Odebunmi (2015, 2013, 2011, 2008), Adegbite (1991), Adegbite and Odebunmi (2006), some of these studies have focused on politeness and facework, which include:

greetings, face negotiation, hedging, face threats. Some of these studies will be reviewed.

The aspect of medical discourse in Nigeria that has generated robust scholarly literature is politeness. Odebunmi (2013) examined greetings and politeness in doctor-patient encounters to unpack the discursive elements that characterize interactive confluence and divergence in selected hospitals. Data for the study were drawn from the natural occurring conversations of doctors and patients who speak the Yoruba language in selected Southwestern Nigerian hospitals.Using Leech's (1983) politeness maxims and Brown and Levinson's (1987) face work as theoretical underpinnings,the study discovered that institutional and cultural (dis)alignments occur in respect of adjacency and non-adjacency pair greetings where adjacency pair greetings attract mutual interpretations between the parties and interactive misalignments are differentially pragmatically accommodated by doctors and clients. In non-adjacency pair greeting, doctors''threats are co-constituted as appropriate by both parties because of the institutional power of doctor and divergent cultural orientation to politeness cues. In other words, doctors and patients use politeness during consultation encounters for face support but sometimes experience interactive clashes which poses a threat on face. Nevertheless, interactive clashes in Odebunmi's study are co-constituted as appropriate by both parties.

In the same vein, 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 revealed that "doctors flout maxims to regulate and mitigate social distance, while the patient uses hedges to curry for the doctors' 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. 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.

In same spirit, Ayeloja and Alabi (2018) consider the discourse implications of politeness in doctor-patient interactions at the University College Hospital, Ibadan, Nigeria. Data for the study are natural occurring interactions of doctors and patients. The data was triangulated by a synthesis of Leech's Politeness maxims and Brown and Penelope's Politeness Theory. The study revealed that 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.

Similarly, Adegbite and Odebunmi (2010) analysed the deployment of face strategies in orthodox and traditional medical practices in south-western, Nigeria. They compared the deployment of bald on record acts, positive politeness, negative politeness and off-record politeness in the orthodox and traditional medical settings. They observed 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.

Furthermore, Olorunsogo, D. (2021) examined how politeness strategies are constructed and their functions in doctor-patient interactions in private hospitals in Akure with an attempt to magnify the interplay of hierarchy between doctors and patients in private medical practice. Audio-taped recordings of doctor-patient

interactions in private hospitals in Akure were were used as study data. Akio Yabuuchi's hierarchy politeness and Jacob Mey's pragmatic act theory were applied to the analysis of data. The study reveals diagnostic elicitation, familiarisation elicitation, emotive pain-alleviation, consultation focusing, and lexical-substitution explanation as strategies used by doctors while complaint focusing is patient-strategy. The pragmatic functions performed through these strategies are investigating, consoling, focusing, complaining, and inquiring. The study data reveals evident polite behaviours within social distance and power. The study finds hierarchy in interactions is relative depending on the type of existing relationship between doctor and patient. This relationship, in turn, determines the type of politeness used.

From the review of previous studies, it is evident that several studies have analysed interactants orientation hospitals in Nigeria but not a significant number on nurses-patients impoliteness in hospitals in Delta state. The present study, therefore, is an attempt to fill the gap in knowledge, to further enrich the body of discourse available in the analysis of impoliteness in Nigerian hospital and update previous studies.

## Methodology

For the purpose of collection of data, NHS Research Ethics Committee Approvals was obtained from the Delta state ministry of health, with which the researcher proceeded to the two hospitals. Data were collected through an unobtrusive observation of nurse-patient interactions in pre-and post-doctors encounters in between 13th June, 2023 and 27th July, 2023. The essence of choosing an unobtrusive observation method is to observe how people speak when they are not aware that they are being observed. To that effect, the researcher did the noting, surreptitiously in order to allow for naturalness and not to deter nurses-patients flow of interactions because when someone knows that their speech is recorded or otherwise observed; they are likely to become self-conscious about their language use. For the

effectiveness of the data collection process and to elicit information easily from the interviewee, the researcher adopts the position of Schilling-Estes (2007:199) who opines that highlighting one's role as a learner and the role of the participants as experts in their communities can go a long way towards obtaining casual speech and building good relationship hence for this research the researcher maximized casualness during the interview.

The population of the study comprises all male and female adult patients and also nurses who have worked inAsaba specialist hospital and General hospital, Okwefor a minimum of two years. The sample size is 10 nurses and two hundred patients; 5 nurses and hundred patients each from the selected hospitals examined. The selection was purposively done to cover a wide range of interactions that took place in pre-doctors and post-doctors consultation encounters during the period under study. Central to the analysis is Culpeper's (1996) impoliteness. The analysis also took in cognizance the researchers knowledge of impoliteness. A qualitative description analysis was carried out on the conversational data and findings were presented in a bar chart.

**Data Presentation and Analysis**

The data were presented under the impoliteness strategies and sub-strategies that they fall into. The data presentation is followed by analysis, for ease of understanding. In some examples, the background of the interaction where actants resulted to impoliteness were stated.

**Bald on Record**

This is considered the most pronounced and obvert form of impoliteness. It is specifically direct, unpretentious and daring. Below are some examples:

**DATA 1:**

Background: (An encounter between an elderly male patient and a young nurse in post doctor's meeting)

Nurse: Who is Okoro Fidelis?

Patient: Am here.

Nurse: Which injection you de take? (Which injection are you taking?)

Patient: I can't remember the name, please help me check.

Nurse: Papa, what kind of stress is this, now? I hate stress. Go and sit down!

Patient: (Walks away slowly)

The above example is a clear case of asymmetrical power relationship that plays out in the hospitals, where patients are usually the vulnerable group since they have the sick role. Most times in the hospital, a patient is expected to sit down with no definite information on when he or she will be attended to. This is one of the major complaints of patients who use the facilities of government hospitals. It is one of the causes of patients' impoliteness. When patients become tired of waiting, they could get frustrated and behave in an uncivil manner to the health personnel. Initially, the conversation in the above example went on smoothly. It follows a question and answer order which defines medical consultation encounters. However, typical flow changed in the nurse's last turn as she introduced complain with an open question "What kind of stress is this, now?" The statement which follows the question, 'go and sit down!' is an order. It is specific, direct and obvious. Although the order was necessitated by the patient's display of uncertainty. The nurse acknowledged the patient as an elderly man yet, ordered him around, after she complained. The patient's next turn, non-verbal action showed that he perceived the impoliteness. In this example, there is power display. The nurse uses impoliteness to display unequal power with the aged patient. Bousfield (2008:222) presupposed that: "impoliteness can indicate a power display, jealousy, anger . . . ".

This instantation is a clear case of asymmetrical power relation defines government hospitals.

**DATA 2:**

Nurses: Who is this Tunde, sef?
Patient: (hurriedly walks into nurse's consulting room) nurse, it's me.
Nurses: (looks at patient, disdainfully) you will wait till anytime am ready to attend to you because have been calling you for the past 20 minutes, now.

In the above instance, impoliteness was initiated by the nurse, right from the opening conversation. Her first turn should have been an interrogative but the insertion of the words; this' and 'sef' accentuates a direct attack on the patient's face. Beyond the utterance, the word 'this' and 'sef' captures the addressee as a worthless fellow. Again, the non- verbal form used by the nurse in her second turnshows a face threat. According to Culpeper (1996: 363), "a number of paralinguistic and non-verbal aspects contribute to the creation of a threatening atmosphere.". In this instance, the nurses' facial look: the widening of eyes and hardening of face signaledimpoliteness. The expression that followed the paralingistic form, you will wait till anytime am ready to attend to you…, is another obvious threat, although, the nurse in a frustrating tone explained her reason for the aggravating expression.

**DATA 3**

Background (A female nurse in her consultation office and a male patient in the open reception waiting to be invited for nurse's consultation)

Nurse: (looks out through door, points to patient) You! You! You! come here! Is it not your turn?
Patient: and so, have you not been attending to people who met me here?

This conversation has one speaking turn. The nurse in her turn abstains from implying meaning in any form, using a directive to call out to the patient. Her first utterance is a direct attack on the patient's face. The repetition of the word 'you' and further expression of anger in her voice has a pragmatic force of an imperative which makes it impolite. There is no gain saying that if the politeness marker *please* was added to the imperative, it would have edged the force. The patient considers the face threatening act and responds similarly with a Bald on Record Strategy. Therefore, he does not try to limit the overtness of his feelings in her response. Both actants did not make any attempt to mitigate face. The patient's closing utterance indicates a negative psychological state, triggered by the nurse's action of ignoring him, to attend to other patients who supposedly came after him.

**DATA 4**

(Background. A nurse in post doctor's post consultation making several attempts to pronounce patient's name correctly)

Patient.Yes

Nurse: What is your name, sef? (gazing into patient eyes, as she stretches out hands with the patient's hospital card)

Patient: (takes card from nurse and shakes head without uttering any word)

The nurse's gaze is intimidating and daring. It couldbe interpreted in words to mean, *I am the superior here, you must submit to me*. The patient appears to the nurse as a person of low class hence, the diminutive 'sef'. Needless to say that if the nurse perceived patients as belonging to the bougeoise, the word '*sef* 'would probably have been eliminated or replaced with, 'sir' to show respect. The patient on his part received the impoliteness and felt hurt. Hence, his closing turn signaled submission in non- verbal form. Nevertheless, the act of taking his card without a thank you is daring. In other thought, appreciation in this particular context may unjustifiable.

**DATA 5**

Background (patient seated in pre-doctor's consultation, for nurse to examine his vital signs) Nurse: Diokpa (elder man) how are you?

Patient: the body no good at all, I no well, I no de sleep well for night. Yesterday, I come dem say make I go do test. This morning I go see doctor he say make I see nurse. Wahala too much for government hospital…. (am not fine at all. I don't sleep well at night. I came yesterday I was asked to run a test, today again, the doctor asked me to see the nurse. I am tired! too much problem with government hospital)

Nurse. (gets uninterested with papa's narrative) Keep quiet let me check your BP.

The above interaction begins with the nurse's enquiry into the patient's state of being. The patient mirrors his state of health and further explains his fustration in seeking medical care in the hospital, precisely, the government hospitals. Through pointed criticism, he attacks the institution and accentuates that the doctor contributed to his negative emotional feeling. The nurse interprets patients complain as attack on the institution where she works. This is an attack on the institution, the nurse perceived it and abruptly employs bald on recordimpoliteness strategy, through which she orders the patient and dismissed his complains. There was no urgency in patient's condition that would have warranted the sudden order but because the nurse felt threathed, she used the institutional power within her corrider to silence the patient.

Usually, in the medical institution, when patients complain, especially the old ones, as in this instance, nurses show emphathybut in this case the old man in his complain attacked the institution and by extension, the nurse who in-turn used her institutional authority to stop the patient from further attack. In

demonstrating a higher power over the patient, the nurse places little or no value on 'face'. In Nigeria context, because of the age difference between the actants, face ought to have been supported but in this case, it is not so. Exercise of power via impoliteness has been discussed earlier in this study's literature review using Maynard (2006) and Odebunmi (2008).

The above conversation is one of such examples where patients makes faulty generalizations about government hospitals. Most times patient don't feel okay when they are meant to go through the process of health care. They blame the health personnel for not doing what they (patients) should have done for themselves. This is crucially challenging for nurses in government hospitals.

**Positive Impoliteness**

The form of positive impoliteness found in nurse-patient interactions in pre- and post-doctors encounters are discussed under the following headings:

(a) Avoid common ground. This is illustrated in **DATA 6 below:**

Nurse. Cover the baby well oo.

Patient: (silence) gently robbing her baby's lap, where she was injected

Nurse. Madam, is okay, cover her well for your good.

Patient. Raise eyebrow to look at the nurse without uttering a word.

The patient denied common ground with the nurse in her baby care concern. Her non-verbal behavior of raising eyebrow at the nurse simply shows arrogance, ignorance and ungratefulness on her part. It is important that mothers listen to and allow the nurses who are professionals and who knows the implications of not taking good care of babies to educate them, accordingly. This patient's actions suggest that some mothers do not take good care of their babies. In other thought, the activities of advising or telling a 'knowledgeable' mother, i.e. a mother who has some prior knowledge of the condition her baby condition is an intrusion. Advice giving is a

potentially face threatening act as they could be perceived by the mothers as an intrusion into their area of expertise. This is particularly true because according to Heritage and Sefi (1992:10), mothers have some prior knowledge of the condition their babies and knows how to take care of them. As a consequence of the mother's knowledge, she ignores and rejects the nurse's attempts at delivering information and giving a piece of advice, thereby challenging the nurse's face, as well as the authority and expertise associated with the nurse's professional role.

**DATA 7:**

Patient: (squeezed her face in anger) Nurse you have not called my sister.
Nurse: What is her name?
Patient: Nancy Patrick
Nurse: Call her...Have she even eaten?
Patient: After the injection, I will get her something to eat.
Nurse: (walking out on patient's relative) No be me and you, una de find who she wan die for im hand (not me and you, you want someone she will die in her hands)
Patient: Okay. Let me go and buy her food. Abeg no vex (sorry, don't be offended)
Nurse: E no concern me. (It is not my business)

In the above example, the patient opens the conversation with a non-verbal impolite form which pronounces her frustration with the institution. She lodges her complain in her state of bitterness. Not unmindful of patients' contenance, the nurse opted for and utilized face negotiation. The manner the nurse introduced and maintained the conversational flow, irrespective of patient's non-verbal arrogancyshows that nurses are able to manage the varied emotions that patients bring to consultation floor. Interaction went on smoothly until the nurse in her third turndenies common ground with patients' relative. The nurses' impolite behaviour however, is from a professional perspective that underlines her responsibility as medical personnel not to give injection without food. She

further, sustains the impoliteness by being non-chalant 'it is not my business'; a behaviour which is uncivil and unprofessional in all sense.

**(b) Being unconcerned-** This sub strategy is evident in **DATA 8,** below:

Background (A male patient who looks like one in his early twenties stands incurious at the nurses' reception)

Nurse: (Through the door, with face squeezed and a fallen jaw, the nurse stares at patient) you…don't you know it's your turn?
Patient: But there is nothing wrong with that.

The above conversation has one speaking turn each from both participants. The patient in reaction to the nurse's question deploys positive impoliteness strategy through which he belittles the nurse. The nurse uses an interrogative as an invitation to summon the patient to consultation. Rather than appreciate the nurse for the reminder, the patient made a snobbish remark. His response '*there is nothing wrong with that'*, equates with the saying, *I have not forgotten*. This shows he doesn't accept responsibility for his absent mindedness, meanwhile he was actually standing aloof when his name was called, before the nurse queried him. Showing lack of concern in acknowledging the nurse's face want is impolite. Culpeper (1996:357) succinctly, states that: positive impoliteness is the use of strategies designed to damage the addressee's positive face want or desire to be respected and appreciate. Anyways, the patients' impoliteness towards the nurse could have been triggered by the nurses' non-verbal behaviour. The ugly look on her face, speaks disrespect. In this instance, impoliteness is seen giving rise to another impoliteness.

**(c)Name calling**

**DATA 9**

Nurse: (Patient hand over the bag containing injection to the nurse) you people can sit there, let me finish with mama.

Patient's relative: (murmuring as they move to the chair with her sister) see face, nkapi (bush rat)

In the above, patient's relative calls the nurse, nkapi, meaning a bush rat. Name calling is consciously employed by the patient's relative to negate the nurse. This example shows that patients and their relatives derive satisfaction in giving nurses a bad image. This kind of situation can be demoralizing and unfair to the nurse who is making effort to assist the patient.

**(d) seek disagreement**

**DATA 10**

Background (In post doctor's consultation, the patients picked offence with the nurse and begin to insult her because of the delay in the hospital. Thenurse looked at her and did not say a word. The patient relative then said

Patient relative: Its okay, she will hear oo.

Patients: abeg, forget that nurse!

The patient was intentionally impolite hence, the refusal for pragmatic adjustment 'abeg, forget that nurse'. Downplaying the fact that she was insulting the nurse shows she wanted disagreement.

**Negative Impoliteness**

The form of negative impoliteness found in nurse-patient interactions in pre- and post-doctors' encounters are discussed under the following headings:

(a) **Frighten**: This is evident in **DATA 11, below**:

(Background. A nurse sent the health assistance to the OPD to tell them to stop sending names. According to her, all the doctors were in the theatre and once they come, they might not be able to attend to all patients whose vital signs had been taken not to more of the ones waiting for their vital signs to be taken. A patient heard and angrily broke into their conversation)

Patient: Wetin be that! (what is that!)

Nures: (softly) Madam, you calm down now.

Patient: I will scatter this place, just try that first.

The above expression, "*I will scatter this place'*" is a threat and it has the tendency to cause fear. By the expression, the patient did not attempt to minimize face threat. The patients' first turn utterance is, however, **invading the others' space**, which is, another substrategy of negative impoliteness. To pry into private conversations of other people is an uncivil act. Irrespective of patientsaggrevating behaviour, the nurse showed empathy downplaying the patients' audacity. The calmness demonstrated by the nurse is a pointer to the fact that nurses could maintain decorum and be rational even in the highest aggrevating behaviour. Many atimes, patientsfails to understand that nurses need to be respected. Most patients tend to respect only the doctors.

**(b) Invade the other's space**

**Example Twelve**

> Nurse: You be Efosa? (are you Efosa) Wetin be your name sef (what is even your name?)".
> Nurse: (calls same name repeatedly)
> Patient: (enters before he could utter a word, the nurse interrupted)
> Nurse.YoubeEfosa? (are you Efosa) Wetin be your name sef (what is even your name?)

The above sequence is an interactional situation where the nurse takes all the turns without observing the patient. This is against conversational etiquette. It is a violation of structure of conversation. Literally, she invades the patients' space by questionioning him and never gave him the opportunity to answer any of the question.

Belittling, is evident in the above instance. Nevertheless**,** it is another substrategy of **negative impoliteness** used by the nurse in her closing turn. The insertion of the Nigerian Pidgin word., *sef***,**' is a diminishing remark used to belittle and shows a negative evaluation of the patient. Needless to say that if the nurse had a

positive evaluation of the patient, the word '*sef*' would have been replace with *sir* or the mitigator *please.*

(c) **Belittle**

This sub strategy of positive impoliteness is evident in the data presented in example two: "Who is this Tunde, sef?" Also, in example 13," What is your name, sef?"". In the contexts of use, the word 'sef' is a diminuitive remark used to reduce the quality self of the people involved.

Beyond the utterance, the word 'sef' potrays the name Tunde as insignificant personality in the contexts of use.

**Sarcasm or mock impoliteness:**

According to Culpepper (1996:356), sarcasm is also mock impoliteness. It is a face threat performed using politeness in a manner that is clearly insincere". This is evident, in the interaction below:

**DATA 13**

Patient: For close to five hours now, doctor i never see (I am yet to see the doctor) nurse (The patient says standing akimbo, looking dejected and exhausted)

Nurse: I told you before that doctors are in the theatre, you are still complaining. govanor, (governor) make dem leave theatre because of you? mtchew (they should abandon critical patients because of you?)

Patient: (looking subdued) Well, I don't blame you.

The intention of the nurse in interaction is to mock the patient's personality. She refers to him as governor; which is denotatively suggests that the patient is a very important personality. Nevertheless, refering to a patient who cannot get preferential treatment, as the number one citizen of a state is sarcasm. The interaction opens with patients complain as he voices his frustration with the delay in the hospital system. The nurse who should have explained respectfully, mocks him. This instance exemplifies what happens in a typical under-developed hospital in

the third world, where there are few doctors to attend to many patients. The nurses themselves are most times over-worked, sometimes they are stresses out and this manifests in their negative language attitude.

**DATA 14**

Background (In the ward, a pregnant woman looking tired, softly sobbing approaches towards a nurse who was seated, head bent down and writing. As she raises her head, sees the pregnant woman approaching her, the following conversation ensues):

Nurse: (raises all fingers and hands to patients' direction) where that one from come out?

Patient: come check me na, abeg.

Nurse: please, please, please. I was not there when you were enjoying the thing, abeg. Waka round the hospital make the baby come down, you de there de shout nurse! Nurse!

The nurses' second turn utterance is a mockery on the sexual relationship between partners.…I was not there, when you were enjoying the thing". She employs euphemism in order to avoid the outright use of the taboo word 'sex'. This is an attempt not to offend the sensibility of the people around. The use and repetitions of the mitigator '*please*' is also clearly not intended for politeness thus insincere. However, **bald on record impoliteness strategy**was used in the opening statement where the nurselodged a face attack with the non-verbal form of positioning her fingers and hands in a most awkward manner, to indicate disgust. The Nigeria Pidgin phrase *'that one'* which follows, isalso a direct insult. This instance points to the manner that nurses in government hospital can be negatively vulgar without consideration for the patient's face.

The above is an exchange rendered in both NigeriaN Pidgin and English, which is one of the interactional features hospitals in Delta state where actants sometimes code-mix and code-switch depending on their linguistic choices and language affordability.

**Withhold Politeness**

According to Culpeper (1996:356), failure to use politeness markers like, thank you, please is withhold politeness. Below is an example to illustrate:

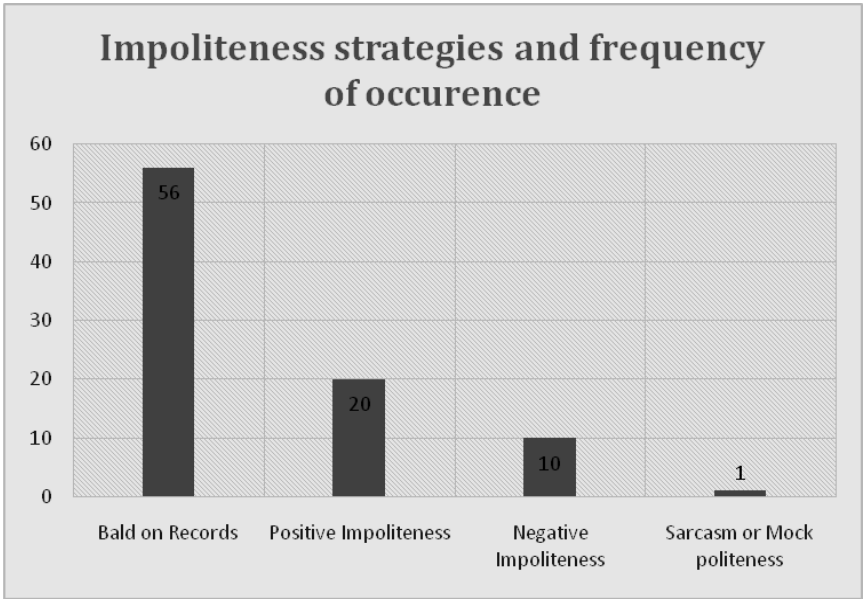
> **DATA 15:**
> Nurse: What is your name, sef? (gazing, as she stretches out hands with the patient's hospital card)
> Patient: (takes card from nurse and shakes head without uttering any word)

In the above instantation, the activity of a patient who takes a card from the nurse and walked away without a sign or word of 'thank you' is impolite but in this context if argued otherwise, may not be taken as impoliteness.

**Findings**

The findings of the study are represented in table 1 below:

**Table 1**



The findings of this study, as shown in table above, reveal that nurses and patients in General Hospital, Okwe and Asaba Specialist during interactions in pre- and post-doctors' encounters utilise bald on record impoliteness strategy, negative impoliteness strategy, positive impoliteness strategy and sarcasmto perform impoliteness. No withhold politeness was identified. The only one that should have been failed because of the peculiar context in which it was used. In their frequencies of occurrence, bald on record impoliteness is 66%, positive impoliteness 20%, negative impoliteness is 10%, sarcasm is 1% and there was no withhold politeness. Again, the study showed that nurses and patients use several paralinguistic features; such as: gazing, hand movement, hardeness of the face and also hissing. These non-verbal cues are used in the context to signal impoliteness even though they were not enlisted as Culpeper's (1996) super strategies. This finding is significant, as it reveals that Culpeper's impoliteness strategy did not consider all possible forms of impoliteness. Nevertheless, as the most comprehensive of all, it is adequate for this study.

Another significant finding is that impoliteness does not exist in isolation. It exists alongside politeness. However, this study focused on the former in order to achieve its aim of showing impoliteness strategies, their and their frequencies of occurence in nurse-patient interactions. Besides using impoliteness to order, downgrade, insult, threathen, the most common use of impoliteness observed by this study is power display. Nurses use impoliteness to show a power higher than the patient. Again, it is pertinent to state that, the examples of interactions used to examine impoliteness were extracted from over seventy sets of conversation, others not examined here, did not have elements of impoliteness. Hence, this study provided a mirrow for the researchers to see polite language behaviour in nurse- patient interactions in both hospitals examined.

## Conclusion

The impoliteness strategies discussed in this work could impact positively on language learning in medical schools. In this regard, some of the findings could be harnessed in planning, adjusting and selecting appropriatetopics to be included in the curriculum of their General Studies courses, like communication in English so that the nurses would learn impoliteness sstrategies in pre- and post-doctors' consultation meetings.and also learn the impact of impoliteness in construing positive relationships for better health outcomes.

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