

BALANCING PATIENT AUTONOMY AND PHYSICIAN AUTHORITY: A POLITENESS PERSPECTIVE ON MEDICAL CONSULTATIONS

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Abstract

This study examines how politeness strategies function in medical consultation discourse to co-construct patient autonomy and professional authority. While doctor–patient encounters inherently involve institutional hierarchy, the study demonstrates that authority and autonomy are not fixed roles but interactional achievements negotiated sequentially through language. Drawing on Brown and Levinson's (1987) Politeness Theory and relational-discursive perspectives, the study employs qualitative discourse analysis of a doctor–patient interaction to explore how authority and autonomy are negotiated sequentially through language. The findings reveal that consultations are organized turn by turn through the strategic use of positive politeness in the form of greetings, appreciation, empathy, negative politeness such as hedging, modalization, conditional phrasing, bald on-record clarity, and collaborative framing using inclusive pronouns such as “we”. The study shows that doctors maintained institutional authority through agenda-setting, diagnostic questioning, and recommendation framing, while mitigating directives to protect patients' face needs and encourage participation. Patients enacted autonomy through narrative elaboration, calibrated symptom descriptions, epistemic claims, and hedged commitments. The findings also reveal that directness in institutional contexts may function as cooperative efficiency rather than impoliteness. The study therefore concludes that authority and autonomy emerge not as oppositional constructs but as interactional achievements co-constructed through turn-by-turn negotiation shaped by institutional norms.

Keywords: Politeness Strategies, Autonomy, Professional Authority, Consultation Discourse, Doctor–patient Interaction, Brown And Levinson Theory

Introduction

Consultation is one of the most significant communicative activities in institutional and professional settings, particularly within the medical context where language functions not only as a medium for diagnosis and treatment, but also as a tool for power negotiation, relationship management, and decision-making. The interaction between a professional and a client in this case, a doctor and a patient involves the continuous negotiation of professional authority and individual autonomy, both of which are discursively constructed through linguistic choices. As consultation moves beyond the simple transfer of biomedical information, it becomes a socially coordinated encounter in which participants strategically manage face concerns, emotional needs, and institutional expectations. Within this interaction space, politeness serves as a key communicative resource for maintaining relational harmony and balancing asymmetrical power relations.

According to Abdallah et al. (2024) and Ogbuehi (2023), communication entails the act of sharing and receiving information through various media, shaped by socio-cultural contexts that influence meaning-making. They further assert that politeness refers to the act of paying attention to others' "face wants," and that the choice of politeness strategies must be guided by contextual principles (Nuryan, 2016). In professional consultations, politeness strategies enable doctors to exercise authority while avoiding coercion, and allow patients to express concerns, preferences, or resistance without threatening professional dominance. Thus, politeness becomes essential not only for interpersonal sensitivity but also for the ethical and collaborative practice of professional communication. Recent scholarship (Djerubu & Daar, 2024; Mayasari & Kamal (2024); Lodhi, et al. 2019) emphasizes how politeness enables doctors to maintain professional dominance while fostering patient participation.

This study therefore aims to investigate how politeness strategies are employed in consultation discourse to negotiate the balance between patient autonomy and professional authority. Specifically, the study is set to examine the linguistic resources used by doctors and patients, such as hedging, indirect requests, deference markers, reassurance, and collaborative framing, and analyze how these strategies function to maintain relational harmony while managing asymmetrical power relations.

Literature Review

Concept of Politeness

The English word 'polite' is drawn from the Latin past participle 'politus' from the verb 'polire' meaning polished or made smooth. Politeness is not a definite or concrete concept. It is the communicative meaning of showing that the face, feeling and wants of other people are considered during communication. Beyond linguistics, there might be other non-verbal ways of showing politeness in communication which manifest themselves in social interaction.

Politeness can be defined as the ways in which language is employed in conversation to show consideration for the feelings and desires of interlocutors, to create and uphold interpersonal relationships, and to comply with the rules for what society or one's culture considers appropriate behavior (Van Olmen, 2022). It is used to describe the relationship that exists between how something is said and the addressee's judgment as to how it should be (Grundy, 2008). Politeness takes into consideration not only what is uttered but also the effect of the utterance on the hearer.

Politeness, Authority, and Autonomy Negotiation

While politeness theory has traditionally focused on mitigating FTAs in everyday conversation, recent research by Gordon and Luke (2011), Bashir (2023), and Latrech and Alazzawie (2022) demonstrate that politeness strategies are not merely about interpersonal sensitivity but are tools for negotiating power, credibility, and participatory rights in institutional interactions where authority and autonomy must be balanced. They observe that politeness strategies also function as tools for negotiating power and participation rights. In institutional interactions where roles are asymmetrical, such as negotiations, professional advisement, or educational supervision, participants use positive and negative politeness to balance authority and autonomy.

Contextual and Cultural Dimensions

A growing body of literature also highlights the contextual variability of politeness. Cross-cultural and digitally mediated communication studies reveal that politeness strategies are adapted to cultural norms, social distance, and communicative medium. Ogbuehi (2025) observes that the way we do things with words functionally relates to the culture of the society. According to her, language relates to culture as an instrument for transmission of its norms, rules and more. Politeness is a manifestation of culturally bound behavior. Sometimes what is considered polite in one culture may not necessarily apply in another culture. For instance, in most African cultures, it is considered inappropriate for a younger person to address an older person by his first name which may not be obtainable in some European cultures. In most African cultures, a younger person is often made to address an older person as “brother” or “uncle” for the male folk, “sister” or “aunty” for the female folk. These terms of address do not necessarily indicate blood relationship but rather an indication of reverence as cultural demands. This supports the notion that politeness strategies in consultation, where institutional norms, power hierarchies, and cultural expectations intersect must be interpreted within a specific communicative ecology rather than as universal, context-free forms (Hu, & Zhou, 2024).

Theoretical Framework

This study is anchored in Brown and Levinson's (1987) politeness theory and complemented by the relational and discursive perspectives on politeness as developed by Watts (2003), Locher (2004), and Mills (2003), which conceptualize politeness as an interactional and contextually negotiated phenomenon. Brown and Levinson's distinction between positive face (the desire for approval and relational connection) and negative face (the desire for

autonomy and freedom from imposition) has been widely applied across institutional and everyday interaction. The model conceptualizes communication as oriented toward the maintenance of face, known as negative face, which relates to the desire for autonomy, independence, and freedom from imposition, and positive face, which is the desire for approval, acceptance, and interpersonal affiliation. Consultation encounters involve recurrent face-threatening acts (FTAs) such as advising, assessing, disagreeing, directing, or questioning. These acts have the potential to threaten either the client's autonomy (negative face) or the professional's authority and competence (positive face).

Relational and Discursive Politeness Perspective

Relational and discursive politeness perspectives argue that politeness is not a static set of strategies to manage interpersonal face needs only (Locher & Watts, 2005; Watts, 2003). They extend this structural model by arguing that politeness is not merely the application of predefined strategies to protect face. Instead, politeness is socially constructed through interaction, shaped by institutional roles, cultural norms, and context (Rajik, 2025: 29). For instance, structurally, Brown and Levinson's (1987) bald-on-record strategy imposes on the addressee's negative face (desire for autonomy), yet it is justified when the social setting permits or demands unambiguous directives such as emergencies and hierarchical power relations.

Methodology

The study adopts a qualitative, discourse-analytic research design grounded in pragmatics and interactional sociolinguistics. This design is appropriate because the research seeks to examine how autonomy and professional authority are negotiated through language use rather than to measure numerical variables. The focus is on identifying, interpreting, and explaining the politeness strategies that participants employ during consultation encounters and how these strategies shape power relations and participation rights.

Data Collection Procedures

Data for the study are obtained through audio-recorded consultation sessions, collected with prior consent from all participants. The interactions are transcribed using a simplified conversation-analytic transcription format to capture pauses, overlaps, hesitations, and emphasis where relevant. Ethical approval and confidentiality safeguards are strictly observed. Participants' names and institutional identifiers are anonymised.

Method of Data Analysis

The data are analysed using a qualitative discourse-pragmatic approach informed by Brown and Levinson's (1987) Politeness Theory and relational/discursive politeness perspectives. Transcribed consultations are subjected to close textual and interactional analysis to identify face-threatening acts (FTAs), politeness strategies (positive, negative, bald on-record, and off-record), and discursive resources such as hedging, mitigation, narrative elaboration, indirect resistance, and inclusive language. Particular attention is paid to how these linguistic choices function sequentially within turns and across adjacency pairs to construct, negotiate, or realign autonomy and professional authority. The analysis proceeds thematically and interpretively, examining how participants orient to institutional roles, power asymmetries, and relational norms in context. Extracts are selected as illustrative cases to demonstrate recurring patterns and interactional mechanisms through which autonomy and authority are co-constructed in consultation encounters.

Data Analysis

The data analysis involves the exemplification of linguistic elements and structures from the data to illustratively demonstrate how politeness strategies such as positive, negative, bald on-record, and off-record, and discursive resources such as hedging, mitigation, narrative elaboration, indirect resistance, and inclusive language function sequentially within turns and across adjacency pairs to construct, negotiate, or realign autonomy and professional authority.

Excerpt 1:

Doctor: "Good morning, Mrs. A. Thank you for waiting. How are you feeling today?"

The doctor's utterance above exemplifies the strategic use of positive politeness in this initial phase of encounter. The greeting formula, "*Good morning*," functions as an interactional opener that establishes social alignment and acknowledges the patient as a legitimate participant in the encounter. The respectful address form, "*Mrs. A*," that combines title and surname, indexes recognition and social respect which reinforces the patient's individuality and status. The expression of appreciation, "*Thank you for waiting*," operates as a face-enhancing move that acknowledges a potential inconvenience and pre-emptively mitigates dissatisfaction. Also, the empathic inquiry, "*How are you feeling today?*" invites the patient's experiential perspective and signals concern beyond procedural necessity.

Each of these elements contributes to constructing a relationally supportive environment. Rather than beginning with a purely task-oriented or diagnostically driven question such as "*What brings you here?*", the doctor

foregrounds rapport and interpersonal sensitivity. This choice shapes the interactional climate by prioritizing connection before clinical interrogation.

By granting the patient early narrative space and expressing appreciation and concern, the doctor frames professional authority as caring, collaborative, and patient-centered rather than directive or distant. In this sense, autonomy is discursively constructed: the patient is positioned not merely as a passive recipient of medical expertise but as an active contributor to the diagnostic process.

From a relational and discursive politeness perspective, this opening demonstrates how politeness strategies function beyond simple face redress. They actively construct institutional identities and shape expectations for participation.

Excerpt 2:

Patient: "Good morning, Doctor. I'm doing fine, sir... although I've been having this chest discomfort lately."

The patient's response above demonstrates a careful negotiation of respect and participation within the institutional setting. The complaint is strategically mitigated. The patient begins with a positive self-assessment "*I'm doing fine*" before introducing the health concern through the softening conjunction "*although*." The lexical choice "*chest discomfort*" rather than a more alarming term such as "*severe pain*," together with the temporal qualifier "*lately*," reduces urgency and minimizes imposition. This hedged presentation reflects sensitivity to professional authority while carefully inserting the patient's concern into the consultation agenda.

From a relational perspective, this exchange illustrates how professional authority and patient agency are co-constructed through strategically managed politeness. While authority is reinforced through deference and mitigation, autonomy is simultaneously constructed through the patient's active introduction and framing of the problem. Thus, autonomy is not asserted confrontationally but enacted through polite, interactionally sensitive language.

Excerpt 3:

Doctor: "Oh, I see. I'm Sorry to hear that. Could you please tell me a bit more about the discomfort- when does it usually start?"

The above doctor's response reflects a strategic combination of positive and negative politeness within the unfolding consultation. The initial acknowledgement, "Oh, I see" functions as a discourse marker of attentive listening that signals uptake of the patient's concern. The expression of empathy, "I'm sorry to hear that" exemplifies positive-face politeness as it validates the

the patient's experience and communicates concern. This move enhances relational alignment by affirming the patient's emotional and experiential reality before transitioning into clinical inquiry.

The subsequent question, "*Could you please tell me a bit more...*," illustrates negative-face politeness through its indirect and mitigated structure. The modal verb "*could*" softens the request by presenting it as contingent rather than imposed, while "*please*" serves as a conventional politeness marker. The phrase "*a bit more*" further mitigates the imposition by minimizing the scope of the requested information. Rather than issuing a directive such as "Describe the discomfort," the doctor frames the inquiry as a courteous request, thereby protecting the patient's negative face while still advancing the institutional agenda.

From a relational and discursive perspective, this utterance demonstrates how clinical authority and patient autonomy are co-constructed: the doctor guides the interaction through structured questioning, but does so in a manner that legitimizes the patient's voice and preserves collaborative engagement.

Excerpt 4:

Patient: "*It mostly happens in the evenings, especially when I'm tired. Sometimes I also feel short of breath,*"

The patient's response above, demonstrates cooperative alignment within the consultation. The utterance directly addresses the doctor's request for elaboration. The tone is neutral, respectful, and clinically oriented, reflecting the patient's orientation to the institutional goal of diagnosis. Rather than resisting or minimizing the issue, the patient provides relevant temporal and symptomatic details that advance the medical inquiry.

Linguistically, the response is marked by clarity and measured specificity. Temporal qualifiers such as "*mostly*" and "*sometimes*" function as calibrated descriptions rather than exaggerated claims that project credibility and reasonableness. The clause "*especially when I'm tired*" introduces contextual framing, while "*I also feel short of breath*" adds supplementary symptom information. These linguistic choices signal cooperation and epistemic responsibility, as the patient carefully reports subjective experience without dramatization. The absence of hedging or overt mitigation here reflects confidence in symptom reporting rather than challenge to authority.

In terms of authority and autonomy negotiation, the patient's turn reinforces professional authority by adhering to the doctor's questioning structure and providing diagnostically useful information. At the same time, autonomy is enacted through the patient's control over experiential knowledge as only the patient can authoritatively describe when and how the symptoms occur.

Thus, while the doctor maintains institutional control of the consultation through questioning, the patient actively contributes to meaning-making by supplying narrative evidence. From a relational perspective, this exchange illustrates collaborative co-construction of the clinical agenda, where authority and participation operate in complementary rather than competing ways.

Excerpt 5:

Doctor: *"Alright, thank you for explaining that. If you don't mind, I'd like to ask a few more questions so we can understand the situation better,"*

The above utterance reflects a strategic integration of positive and negative politeness within the ongoing consultation. The expression of appreciation, *"thank you for explaining that,"* exemplifies positive-face politeness, as it acknowledges the patient's effort and validates their contribution. This appreciation reinforces relational alignment and affirms the patient's role as an active and valued participant in the interaction rather than a passive recipient of medical authority.

The clause *"If you don't mind"* functions as a conventional negative-face politeness marker. It frames the upcoming questioning as contingent upon the patient's willingness, thereby minimizing imposition and symbolically recognizing the patient's autonomy. Similarly, the construction *"I'd like to ask"* (rather than *"I will ask"* or *"I need to ask"*) mitigates directive force through modal softening. The quantifier *"a few more questions"* further reduces perceived burden, suggesting limited imposition. These linguistic features collectively demonstrate sensitivity to the patient's negative face even as the doctor advances the institutional agenda of diagnostic inquiry.

The collaborative framing, *"so we can understand the situation better,"* is particularly significant from a relational and discursive perspective. The inclusive pronoun *"we"* constructs shared epistemic responsibility and positions diagnosis as a joint endeavor rather than a unilateral professional act. The professional authority and patient autonomy are co-constructed through appreciation, mitigation, and inclusive language that sustain participation while legitimizing institutional direction.

Excerpt 6:

Patient: *"Yes, of course,"*

The above patient's response functions as an agreement marker that indicates polite acceptance of the doctor's authority to continue questioning. By responding affirmatively and without hesitation, the patient validates the doctor's institutional role and acknowledges the structured flow of the consultation, thereby sustaining relational and professional norms.

Linguistically, the phrase “*of course*” enhances the affirmation beyond a simple “yes,” conveying cooperative engagement and readiness to participate. It simultaneously indexes respect for the doctor's negative face by allowing the doctor to advance the agenda without resistance, while also reinforcing the patient's positive face through courteous compliance.

In terms of authority and autonomy, the patient temporarily cedes control of the conversational agenda, yet subtly maintains autonomy through active and willing participation. Relationally, this turn exemplifies how politeness and alignment facilitate smooth negotiation of authority and collaborative engagement in clinical discourse.

Excerpt 7:

Doctor: “*Have you noticed whether the pain increases when you walk fast or climb stairs?*”

This utterance exemplifies a mitigated questioning strategy, combining indirectness and sensitivity within a diagnostic inquiry. The use of the interrogative “*Have you noticed whether...*” frames the question as an invitation for observation rather than a directive or evaluative challenge. This mitigates imposition on the patient, thereby reflecting negative-face politeness, as it respects the patient's autonomy while requesting information critical to clinical assessment.

Linguistically, the turn is carefully structured to reduce pressure. The modal phrasing “*Have you noticed*” shifts the epistemic responsibility to the patient's personal experience, rather than asserting the doctor's knowledge. The embedded clause “*when you walk fast or climb stairs*” provides clarification and narrows the scope of response, supporting cooperative engagement and guiding the patient without exerting overt authority. This approach balances institutional objectives with relational sensitivity to ensure that the patient feels invited to contribute rather than interrogated.

From a discursive perspective, professional authority is exercised through question formulation and agenda control, yet the indirectness and mitigated structure demonstrate relational politeness. The doctor's linguistic strategy co-constructs a space where patient autonomy is respected, while clinical authority is maintained through guided inquiry, enabling collaborative meaning-making in the consultation.

Excerpt 8:

Patient: “*Yes, it does. That's when it gets worse,*”

This response from the patient demonstrates cooperative alignment within the consultation sequence. The patient provides a clear and concise answer to the doctor's mitigated diagnostic question, thereby contributing relevant symptom information. The tone remains respectful and neutral, signaling acknowledgment of the doctor's authority and maintaining relational harmony.

The patient's utterance, "Yes, it does. That's when it gets worse," appears structurally simple and direct. From a Brown and Levinson perspective, it approximates a bald on-record response because it is clear, concise, and unmitigated. There is no hedging ("I think"), no softeners ("maybe"), and no elaborate politeness markers. The patient gives a straightforward confirmation followed by an explicit clarification.

However, unlike classic bald on-record commands or criticisms, this utterance does not perform a face-threatening act. Instead, it functions as a cooperative response within the institutional frame of a medical consultation. The patient directly answers the doctor's question, thereby aligning with the interactional goal of diagnosis. In this sense, the baldness here signals epistemic certainty and experiential authority. The patient claims ownership of bodily knowledge, "that's when it gets worse" which positions her as the primary knower of the symptoms.

From a relational and discursive politeness perspective, the evaluation of this directness depends on context. In everyday conversation, such brevity might appear abrupt. In the hospital setting, however, institutional norms prioritize clarity, efficiency, and accuracy. The patient's direct response supports the medical agenda rather than threatening relational harmony. Thus, the utterance enacts cooperative professionalism rather than impoliteness. This example illustrates how bald on-record strategies are not inherently impolite. Their interpretation depends on interactional goals and institutional expectations. Here, directness functions as a resource for efficiency and accuracy, rather than as a face threat. It reinforces the consultation's clinical focus while allowing the patient to assert experiential authority within acceptable institutional boundaries.

This turn also exemplifies how authority and autonomy are co-constructed. The patient defers to the doctor's investigative agenda, demonstrating respect for professional authority, while simultaneously exercising autonomy through control over personal symptom knowledge. The exchange illustrates a collaborative interactional dynamic where polite alignment and informative contribution enable effective consultation without undermining hierarchical or professional structures.

Excerpt 9:

Doctor: *"Okay. From what you've described, it might be related to your heart, but we'll run some tests to be sure,"*

This utterance by the doctor demonstrates a balance of authority, reassurance, and mitigated communication within the consultation. The preface *"From what you've described"* acknowledges the patient's contribution, reflecting positive-face politeness by validating the patient's narrative and experience. This positions the patient as an active participant in constructing the clinical picture, reinforcing relational alignment and shared understanding.

The modal phrasing “*it might be related to your heart*” exemplifies negative-face politeness by softening potential threat or anxiety associated with a preliminary diagnosis. The uncertainty conveyed through “*might*” avoids imposing a definitive judgment, thus protecting the patient's emotional autonomy. The follow-up “*but we'll run some tests to be sure*” functions as both reassurance and a collaborative statement, signaling inclusive engagement in the diagnostic process. This aligns with discursive strategies that maintain professional authority while demonstrating empathy and patient-centered care.

From a discursive perspective, the utterance constructs a space where the patient's autonomy and emotional security are preserved, while the doctor maintains professional credibility and guides the consultation collaboratively.

Excerpt 10:

Doctor: “*I'd like to suggest an ECG and a blood pressure check. How does that sound to you?*”

The above utterance exemplifies a combination of negative-face politeness and collaborative framing in clinical decision-making. The phrase “*I'd like to suggest*” mitigates the imposition of medical recommendations, softens the directive nature of the proposal, and respects the patient's autonomy. By presenting the tests as a suggestion rather than a command, the doctor protects the patient's negative face, the desire for freedom from coercion, while maintaining professional authority over the consultation agenda.

Linguistically, the turn incorporates an inclusive and participatory element through the follow-up question “*How does that sound to you?*” This invites the patient to evaluate, respond to, and co-author the proposed plan, which demonstrates collaborative engagement. The combination of mitigated proposal and open-ended solicitation functions as a discursive resource that aligns professional expertise with patient agency. It signals respect for the patient's perspective while guiding decision-making toward clinically appropriate actions.

From a discursive perspective, the doctor exercises authority through agenda-setting and recommendation, yet relationally balances this with politeness strategies that invite participation. This utterance illustrates how autonomy and authority are co-constructed: the patient is positioned as an active participant in evaluating the suggested interventions, while the doctor retains institutional control framed within a respectful and collaborative interaction.

Excerpt 11:

Patient: “*That sounds fine, Doctor,*”

The above response from the patient demonstrates cooperative alignment and polite acceptance of the doctor's proposed plan. The affirmation “*That sounds fine*” functions as a positive response to the previous adjacency pair (*Proposal/Acceptance*). It signals agreement with the suggested tests while maintaining a respectful and neutral tone. By adding the honorific “*Doctor,*” the patient reinforces deference to the professional's authority, sustaining relational and institutional norms.

Linguistically, the turn is concise but interactionally significant. The phrasing “*sounds fine*” provides acceptance without elaboration or challenge, which reflects politeness and recognition of the doctor's expertise. This demonstrates positive-face politeness through acknowledgement of the doctor's role, while also showing cooperative engagement in the decision-making process.

This utterance concludes the current decision-making sequence that allows the consultation to progress toward the next clinical step. In terms of authority and autonomy, the patient temporarily cedes control by accepting the recommendation, yet autonomy is subtly maintained through the voluntary expression of agreement. From a relational and discursive perspective, the turn exemplifies collaborative interaction, where authority and patient participation are harmoniously negotiated through polite and respectful communication.

Excerpt 12:

Doctor: “*Great. Also, if it's okay with you, I would advise that you avoid strenuous activities for now. You may also want to reduce salt and fried foods in your meals,*”

The above utterance demonstrates a combination of negative-face politeness, mitigation, and collaborative framing within the consultation. The prefatory phrase “*if it's okay with you*” softens the directive, presenting lifestyle recommendations as conditional rather than imposed. This protects the patient's negative face while maintaining professional authority and guidance.

Linguistically, mitigation is achieved through modal verbs such as “*would advise*” and “*may also want to*”, which reduce the force of the recommendations. The advice is framed as optional and non-coercive, inviting the patient to participate in decision-making. The sequential listing of concrete behavioral suggestions such as avoiding strenuous activity, reducing salt, and limiting fried foods provides actionable guidance while remaining respectful of the patient's agency. The inclusive tone and phrasing indicate collaboration that positions the patient as an active contributor to their health management.

From a discursive perspective, the utterance illustrates how professional authority and patient autonomy are co-constructed: the doctor guides the patient's health decisions while ensuring that recommendations are presented politely, allowing for patient engagement and voluntary adherence.

Excerpt 13:

Patient: “*Alright, I'll try to do that,*”

This utterance demonstrates polite acceptance and cautious commitment in response to the doctor's recommendations. The opening token “*Alright*” signals acknowledgment and alignment with the advice. While the modal phrase “*I'll try*” functions as a hedged commitment that softens the assertion and maintains flexibility. This mitigates potential face threats by avoiding an

absolute promise, thereby respecting the patient's own autonomy while still cooperating with the doctor's guidance.

Linguistically, the turn balances deference and agency. The hedging “*I’ll try*” allows the patient to demonstrate willingness without over committing herself. It reflects sensitivity to the relational dynamics of authority and personal capacity. The phrase “*to do that*” refers back to the specific behavioral advice which reflects attentiveness and understanding of the medical guidance while maintaining a respectful tone.

From a relational and discursive perspective, the patient's response illustrates how autonomy and authority are negotiated: the doctor's professional authority is acknowledged and respected, while the patient retains agency through cautious, mitigated acceptance. The interaction thus maintains a collaborative, polite, and professionally appropriate exchange.

Discussion of Findings

This study sets out to examine how politeness strategies function in medical consultation discourse to negotiate and co-construct patient autonomy and professional authority. Drawing on Brown and Levinson's (1987) Politeness Theory and relational-discursive perspectives, the findings demonstrate that consultation is not merely an exchange of biomedical information, but a sequentially organized interaction in which authority and autonomy are dynamically managed through linguistic choices.

The analysis confirms earlier scholarship (Djerubu & Daar, 2024; Mayasari & Kamal, (2024); Lodhi, et al., 2019) which argues that politeness strategies enable healthcare professionals to maintain institutional authority while encouraging patient participation. Across the excerpts, doctors consistently employed positive politeness (greetings, appreciation, empathy markers), negative politeness (modal verbs, conditional phrasing, indirect requests), and collaborative framing (inclusive pronouns such as “we”) to soften directives and protect the patient's face. These findings align with previous discourse-analytic studies showing that mitigation, hedging, and inclusive language are central to patient-centered communication.

However, this study extends existing literature by demonstrating more explicitly how autonomy and authority are co-constructed sequentially within adjacency pairs. Authority was not exercised through overt dominance but through agenda control, diagnostic questioning, and recommendation framing.

At the same time, autonomy was enacted through narrative elaboration, calibrated symptom descriptions, hedged commitments such as “*I’ll try*” and experiential claims such as “*That's when it gets worse*”.

This supports relational politeness theorists who argue that politeness is not merely a set of static strategies but an interactional achievement negotiated turn by turn.

The findings also nuance Brown and Levinson's categorization of bald on-record strategies. While bald on-record forms are often associated with face threat, the data show that directness in institutional settings may function as cooperative efficiency rather than impoliteness. The patient's concise confirmation "Yes, it does" illustrates how epistemic certainty can reinforce experiential authority without challenging professional hierarchy. This observation resonates with discursive politeness perspectives, which emphasize contextual evaluation rather than structural classification alone.

Furthermore, the findings reveal that mitigation does not necessarily weaken professional authority. Instead, modal constructions such as "I'd like to suggest" or "You may want to" allowed doctors to maintain control of the consultation while framing decisions collaboratively. This supports studies in healthcare communication that link mitigated language with enhanced trust, reduced anxiety, and improved patient adherence. The inclusive pronoun "we" was particularly significant in constructing shared responsibility, reinforcing the notion that diagnosis and treatment planning are joint enterprises rather than unilateral professional acts.

Implications of the Study

The study has important implications for medical education and professional communication training. First, it highlights the need to train healthcare practitioners not only in clinical competence but also in strategic communicative competence. Awareness of how modal verbs, empathy markers, inclusive pronouns, and mitigated directives shape relational outcomes can enhance patient trust and cooperation. Second, fostering sensitivity to discursive constructions of autonomy may improve shared decision-making practices, particularly in contexts where hierarchical norms might otherwise limit patient voice.

For healthcare institutions, the findings suggest that promoting patient-centered communication does not require diminishing professional authority. Rather, authority can be exercised relationally through politeness strategies that invite participation while preserving institutional roles. This balance is crucial for ethical and effective healthcare delivery.

Conclusion

This study has so far examined how politeness strategies are employed in medical consultation discourse to negotiate the balance between patient autonomy and professional authority. The findings reveal that consultation is a sequentially organized communicative event in which positive politeness (greetings, appreciation, empathy), negative politeness (hedging, modalization, conditional phrasing), bald on-record clarity, and collaborative framing (inclusive pronouns, negotiated proposals) function as key linguistic resources. Doctors maintained institutional authority through agenda-setting, diagnostic questioning, and recommendation framing, yet consistently mitigate directives to protect the patients' face needs. At the same time, patients enacted autonomy through narrative elaboration, calibrated symptom descriptions, epistemic claims, and hedged commitments. Thus, authority and autonomy were not oppositional constructs but were co-constructed interactionally through turn-by-turn negotiation shaped by contextual and institutional norms.

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